Program for All Inclusive Care for the Elderly (PACE)

FEASIBILITY STUDY

Prepared for

for PACE Development in

Northern Virginia

Palmetto Health Senior Consulting

May 2008

Feasibility Study
performed for:

Fairfax County

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I. INTRODUCTION

The County of Fairfax (Fairfax County) engaged Palmetto Health Senior Consulting in Columbia, South Carolina to conduct a feasibility study to determine the viability and financial outlook for the operation of a Program for All-Inclusive Care for the Elderly (PACE) in Northern Virginia.

The targeted service area for a Northern Virginia PACE program is Fairfax County, Fairfax City, Falls Church City, Arlington County, and Alexandria City – this area will be referred to 'Fairfax' for the reminder of this report. Fairfax forms a large part of the Washington DC Metropolitan area and is primarily populated by professionals working in the federal civil service, the U.S. military, or for one of the many private companies which contract to provide services to the federal government. Fairfax is made up of some of the most densely populated areas in Virginia and as of 2007 had an estimated population of 1,077,000. Fairfax is also one of the most affleunt in the country. Fairfax County has the highest median household income ($100,318) of any county in the United States, and five other Northern Virginia counties ranked among the twenty (20) U.S. counties with the highest median household income in 2006, as reported by *Forbes*.

A 2006 Fairfax County report, *Anticipating the Future: A Discussion of Trends in Fairfax County,* cited Northern Virginia and the metro area as having the most diverse foreign born population outside of New York City. Based on recent data from the 2005 American Community Survey, 23% of older Fairfax residents are Asian, Muslim, or Hispanic/Latino and most speak a non-English language at home.

Looking ahead, the number of older Asians will double over the next ten years. The older Hispanic/Latino is projected to increase by approximately 10% per year. The *Anticipating the Future* report projects that if the same trends and rates that occurred between 1990 and 2000 continue through 2010, approximately 45% of Fairfax County's total population may be racial and ethnic minorities and 39% may speak a language other than English at home.

V*irginia's State Plan for Aging Services: 2007-2011* published in October 2007 states that Virginia's growing linguistic and cultural diversity is "challenging local Area Agencies on Aging to change the way in which they provide services … [because linguistic and cultural barriers] can lead to legal challenges being brought against public agencies for violation of the Civil Rights Act, which mandates equal access to public programs and services for all individuals."

The findings summarized in this feasibility report are designed to:

- Furnish a basis for sound judgments about the feasibility of PACE implementation in Fairfax;
- Provide sound assumptions and supply information needed to create a solid and reliable financial proforma and business plan; and
- Support recommendations from stakeholder management and the governing body for a decision regarding PACE development in Fairfax.

Initial Fairfax County interest in PACE development began in 2002 with the preparation and completion of the *Strategic Plan for Long Term Care in Fairfax County.* Interest in PACE continued when the Virginia Department of Medical Assistance Services (DMAS) was awarded one of the Accelerating States Access to PACE (ASAP) grants. Virginia was one of eight states funded by

CMS through the National PACE Association (NPA) to identify barriers and opportunities related to PACE development. NPA's assessment of barriers and opportunities for PACE development in Virginia examined the potential need for services across three potential service areas; the likelihood of health, aging services and housing providers initiating a PACE program; and the role of state agencies in supporting the development of a PACE program. The study indicated a strong interest and need in the Fairfax market for community-based alternatives for long-term care such as PACE.

As a result of increased interest and a perceived need for a PACE program in Fairfax, in June of 2004 the Fairfax County Council of Governments engaged Palmetto Health Senior Consulting (PHSC) to determine the viability of developing PACE in the Fairfax market. A significant challenge at the time was the inability of the County to be the PACE provider due to the requirement that the PACE provider bear full financial risk. The key focus during the initial feasibility phase was to identify a provider or group of providers that would be interested in developing a PACE program with the assistance of and in collaboration with Fairfax County. Since Fairfax County could not serve as the PACE provider, it was communicated to various providers that the County would provide assistance through collaboration and the potential for a limited amount of start-up funding. The focus at the time was on the adult day care providers in the area and several meetings and focus groups were organized by the County to assess interest and to begin the initial strategic planning process for PACE in Fairfax. Although the County fervently attempted to locate an organization to serve as the PACE provider, efforts to locate such a provider were unsuccessful and the feasibility process stalled in 2006.

In 2007, a group of providers including Birmingham Green, Capital Hospice, Inova Health System - Long Term Care Division, Goodwin House, Korean Senior Center, Evergreen Home Care, and formed to reinitiate discussions about the prospect of starting a PACE organization in Fairfax. Each organization recognized an opportunity to expand their missions through the PACE model and were interested in exploring options for providing an additional community-based model of care for the frail elderly.

The following are brief descriptions of each of the organization in the potential Fairfax PACE program:

Birmingham Green is the non-profit partner for Northern Virginia area local governments and provides a continuum of exceptional long-term care services for adults, primarily those with limited resources. Birmingham Green is an innovative leader in the field of long-term care providing a quality of life for its residents that recognizes their dignity and encourages their functioning at a maximum level of independence.

Capital Hospice was founded in the 1970's and serves Maryland, Virginia, and the Washington DC market. Capital Hospice provides home health and hospice services and operates a 14-bed inpatient center licensed as an acute care facility. The organization serves over 800 patients at any given time and is well respected in the community with close working relationships with the provider group interested in PACE development.

Inova Health System operates five hospitals in Northern Virginia. Inova Fairfax Hospital has been ranked by *U.S. News & World Report* as one of "America's Best Hospitals." The long term care

division operates nursing homes, assisted living programs, and Elderlink. ElderLink was created out of a public-private partnership among Inova Health System, the Fairfax Area Agency on Aging, and the Alzheimer's Association of Northern Virginia. ElderLink coordinates and manages all elements of patient care (medical, social, legal, financial), minimizing the stress and confusion families often experience when dealing with multiple service providers.

Goodwin House is a life care facility serving middle to upper income populations through facilities which are currently being expanded. Guided by the high standards of the Episcopal Church, Goodwin House is a faith-based, nondenominational organization committed to providing the finest quality to those they serve. Goodwin House Alexandria and Goodwin House Bailey's Crossroads are two of the most preferred retirement communities in Northern Virginia, offering high quality facilities, amenities, and services to support a vibrant lifestyle.

The volunteer-run Korean Senior Center has substantial experience in developing and managing a growing range of services for active older Koreans in Fairfax. Currently, it operates the only ethnic-specific community senior center, provides Korean Meals on Wheels, and four years ago pioneered the development of a Virginia Department of Medical Assistance Services-certified training program for Korean personal care aides that has been replicated to the local Hispanic and Muslim communities. The Korean Senior Center's PCA program has been recognized by the Commonwealth of Virginia's General Assembly (House Joint Resolution 928) as a model for other communities.

Evergreen Home Care assists Asian families seeking to provide traditional care for elders at home while dealing with the financial and work realities faced by modern multi-cultural and multi-generational families in the Washington, DC area. After being relatively inactive since its nonprofit incorporation in 2001, Evergreen Home Care's Chinese-American founders in 2007 designated a new president and adopted a strategic plan to develop programs for health information and transportation access and partner with other ethnic community organizations to develop multi-ethnic home support services.

The PACE model of care is consistent with the missions of the collaborating stakeholder organizations and potentially offers the following benefits to the frail elderly residents in Fairfax.

- a community-based long-term care alternative targeted to meet the needs of one of the community's most vulnerable populations, the frail elderly; by providing resources and services to assist families and caregivers in meeting the long term-care needs of their loved ones, PACE enables participants to stay in their homes and community for as long as possible;

- a potentially financially feasible and sustainable program that leverages both Medicare and Medicaid funding at the local level; projections indicate that by the end of the 5th year of operations a PACE program in Fairfax projects to generate a revenue base of just over $10 million and create 38 new jobs;

- the opportunity to develop partnerships with other community health and long-term care providers, and a program that involves the community in areas of governance and quality by enlisting the support of families and caregivers in directing how the program is designed and operates.

The PACE program is the first program to be established as a permanent provider under Medicare since Hospice. Based on the successful On Lok capitated long-term care model in San Francisco, PACE allows individuals with long-term care needs to remain in the community rather than be placed in a nursing home. PACE combines direct services such as adult day health and primary care with a network of community providers such as physician specialists, ancillary providers, hospitals, and nursing homes to create a comprehensive service delivery system.

PACE program revenue is generated by pre-paid monthly capitated payments from Medicare and Medicaid. Most PACE participants will be eligible for both Medicare and Medicaid and PACE programs receive a monthly capitation payment from both payer sources for each participant. Medicaid monthly capitation rates are established by the Virginia Department of Medical Assistance (DMAS). Medicare monthly capitation payments are based on individual enrollees' age, gender, Medicaid status, whether the beneficiary was originally disabled, diagnoses, and an organizational-level frailty adjuster. The Centers for Medicare and Medicaid Services (CMS) utilizes the CMS-HCC (Hierarchical Condition Categories) risk adjusted payment methodology to adjust payments for enrollees' demographic characteristics and diagnoses; this model is the basis for risk adjustment for Medicare Advantage organizations. CMS calculates an organizational-level frailty adjuster based on PACE enrollees' responses to the Health Outcomes Survey – Modified (HOS-M). The frailty adjuster is intended to account for Medicare expenditures for a community-based, functionally impaired population that are not explained by the CMS-HCC risk adjustment model.

The critical factors for successfully developing and operating a PACE program are:

- *Market potential:* An adequate number of PACE eligible persons living in the service area;

- *Marketing efforts:* Consistent marketing and outreach efforts to ensure a steady growth of referrals and enrollments, especially during program start-up;

- *Service control:* Control over core service components – PACE Center services, home care, and primary care - through direct provision of these services by PACE staff;

- *Interdisciplinary Team:* Establishment of an interdisciplinary team where team members strive for consensus in treatment goals, service delivery, and mutual accountability. A strong interdisciplinary team will:

    - Employ effective and efficient communication and coordination to ensure appropriate and timely responses to the changing needs of the enrollees;

    - Emphasize each team member's roles in providing, managing, and integrating care for enrollees; and,

    - Maintain the health status and functional independence of enrollees in order to minimize costly hospital and nursing home care

- *Start-up capital:* Sufficient start-up and working capital to cover program costs until the program reaches break-even.

PACE is a model of care that enriches the lives of its participants and families. It is impossible to place a value on living at home surrounded by friends and family verses being forced to live in a nursing home. PACE offers that opportunity to the frail elderly in the communities that it serves.

II. Overview of the PACE Model

As a component of the 1997 Balanced Budget Act, PACE was established as a permanent provider under both Medicare and Medicaid. The final PACE federal regulation was published December 6, 2006 by CMS and is available on the Internet at http://www.cms.hhs.gov/PACE/Downloads/finalreg.pdf. A PACE home page on the CMS website - http://www.cms.hhs.gov/PACE/ - is devoted to providing information about PACE to operational PACE providers, organizations interested in becoming PACE providers, and State Administering Agencies. Appendix A of this report contains a general "PACE Fact Sheet" published by CMS that includes additional information on PACE development, PACE operations, the application process, and other useful information.

As of May 2008, there are forty-eight (48) PACE programs operating in twenty-four (24) states, including Virginia, and many other organizations nationwide are in different stages of PACE development. Appendix B contains the National PACE Association's listing of PACE organizations nationally as of May 1, 2008. This list also includes "pre-PACE" organizations that operate under Medicaid capitation only. Pre-PACE organizations are not considered PACE organizations and are not required to operate in compliance with the PACE regulation; however, they are included on this list.

Eligibility for PACE is restricted to those who are:

- Age 55 or older;
- Certified by the state of Virginia as eligible for nursing home level of care;
- Residents of a specified geographic area; and
- At the point of enrollment can be safely cared for in a community setting.

Once persons are enrolled as PACE participants their care and services are coordinated by the PACE Interdisciplinary Team (IDT) through the plan of care. The IDT establishes the plan of care at enrollment and reassessments are conducted at least twice a year (reassessments may occur more often based on changes in a participant's health condition or anticipated needs). The plan of care is developed by the IDT based on the individual discipline-specific assessment of each IDT member.

The federal PACE provider regulations require the IDT be comprised of individuals from ***at least*** the following disciplines:

- Primary Care
- Social Work
- Nursing
- Personal Care
- Home Care
- Pharmacy
- Transportation
- Recreational Therapy
- Occupational Therapy

- Physical Therapy, and
- Nutrition

The IDT meets on a regular basis (once or twice a week) to establish the plan of care for new enrollees, conduct reassessments of existing plans of care for current enrollees, and communicate any pertinent information regarding participants or the program. In addition, a 'Morning Meeting' is usually effective in communicating the daily schedule of events and any information regarding participants that needs to be shared at the PACE Center level. The IDT must provide high quality care while controlling program costs. Capitated funding provides an incentive for coordinating care through preventive and supportive services. By maximizing independence and health, an effective IDT will be able to reduce inpatient and skilled nursing facility utilization and lower participant expense.

The average PACE participant is over eighty years old and has an average of eight acute and chronic medical problems such as heart disease, respiratory disease, and diabetes. The majority of participants are cognitively impaired, suffering from Alzheimer's disease and/or other dementias, and are severely impaired in several activities of daily living such as walking, bathing, dressing, and toileting. This profile of a typical PACE participant demonstrates that PACE providers must be willing to serve an extremely frail population and must provide an intensive level of medical and social services.

The PACE Center is the focal point of the program and combines the services of an adult day health center, primary care clinic, and rehabilitation facility in to a single location. Transportation and in-home services are coordinated at the PACE Center level while inpatient services (hospital and nursing home) and outpatient and physician specialist services are typically provided through contractual agreement with community providers. Additional required services such as meals and recreational therapy are provided in the PACE Center.

III. PACE in Virginia

As the State Administering Agency for PACE, the Virginia Department of Medical Assistance and Services (DMAS) is responsible for the development and administration of PACE programs in Virginia. In addition, Virginia DMAS oversees and monitors all aspects of PACE programs in the state and guides and assists PACE programs during the development phase. Virginia currently has four operational PACE programs and two other providers are in the provider application approval phase. Two of the operational programs are recipients of the CMS Rural PACE grants and are located in the southwestern area of the state.

Virginia PACE Programs

Sentara Senior Community Care – Tidewater (Virginia Beach)
Riverside PACE – Tidewater (Newport News)
Mountain Empire PACE (rural) – Big Stone Gap
AllCARE for Seniors (rural) – Cedar Bluff

Riverside PACE – Richmond – opening late 2008
Centra PACE – Lynchburg – opening early 2009

DMAS establishes the Medicaid monthly capitation rates for PACE. PACE providers are assigned to a region based on their geographic location. Rates are calculated annually in consultation with an actuary and reflect the comparable costs of serving potential PACE enrollees through alternative programs. This is important given the differences in underlying costs for the Fairfax area, Central Virginia (Charlottesville and Richmond), the Tidewater area, and Southwestern Virginia. The 2008 rates for PACE in Northern Virginia have been set at $3,533.48 per participant per month for dual eligible beneficiaries. This rate compares favorably to rates being received by PACE programs nationally.

Potential PACE providers in Virginia should establish a relationship with DMAS and communicate regularly with DMAS on all organizational PACE development activities. DMAS will be responsible for approving each PACE provider's service area, calculating the Medicaid capitation rate, and submitting the PACE provider application to CMS on behalf of the provider. The provider application includes assurances from DMAS that it is willing to enter into a PACE program agreement with the provider upon application approval by CMS.

IV. Applying for Provider Status

Organizations must have an approved PACE provider application from CMS prior to becoming operational as a PACE program. Once the provider application is submitted to CMS by Medicaid, there are two 90-day review periods and a "readiness review" of the PACE Center by DMAS. Once CMS has approved the provider application, a three-way program agreement (contract) between the PACE organization, DMAS, and CMS is executed and PACE provider status is awarded.

The PACE provider application describes the organization's intent to operate the program in compliance with the PACE regulations. The organization, with the approval of the SAA (DMAS), may submit to CMS a request to waive a particular requirement of the regulation along with justification for the waiver request. Waiver request(s) should be submitted with the provider application; however, they may also be submitted at any time during the life of the program, as needed.

In addition to the provider application, organizations must submit to CMS an application to become a Prescription Drug Plan (PDP) under the Medicare Part D program. The National PACE Association's (NPA) summary of the final Part D regulation as it relates to PACE can be found in Appendix C. PACE organizations must provide the Medicare Part D benefit to its PACE participants as an authorized PDP. The most critical component of the Part D approval process is the submission and ultimate approval of the premium proposals. The premium proposals, which must be actuarially certified, are the organization's estimate of the costs of providing the pharmacy benefit to PACE participants (dual eligible and 'Medicare-only'). The premium proposals must be submitted to CMS at least six months prior to the date the PACE program expects to become operational and must be re-certified and submitted to CMS annually.

V. The PACE Provider Application

The PACE provider application is the document that outlines the strategic plan for the implementation of a PACE program. The application addresses how the program is governed, operates, and delivers services to those individuals enrolled in the PACE program. It reflects the financial resources of the provider to manage the deficits the program incurs until a census is achieved that allows the program to generate revenue sufficient to cover expenses. While the PACE provider application is prepared by the potential PACE provider, it must be submitted by DMAS on behalf of the provider along with assurance it is willing to enter into a PACE program agreement with the provider. During the application process, DMAS will conduct an on-site State Readiness Review of the PACE Center. The final step in the process will be the implementation of a 3-way agreement between the SAA, the PACE provider, and CMS.

The PACE provider application will require the following information in order to determine if an organization is prepared to provide PACE services:

- Program's administrative structure and relationship to sponsoring organization;
- Detailed explanation of program's service delivery approach, including identification of which services will be provided directly versus through contractual arrangements;
- Evidence that the PACE Center and staff are prepared to begin operations;
- Identification of key administrative and clinical staff, e.g., program director, medical director, other administrative staff;
- Development of a contract provider network that covers all Medicare and Medicaid services;
- Marketing plan and marketing materials;
- Program policies and procedures, including grievance and appeal and enrollment and disenrollment procedures;
- Evidence of care protocols, explaining processes for assessment, care planning and delivery;
- Explanation of process for determining prospective enrollees' clinical eligibility;
- Program's quality assurance and performance improvement (QAPI) plan and evidence of program's capability to meet quality reporting requirements;
- Evidence that all state and local licensing and certification requirements have been met;

- Appropriate assurances from the state that the program has met the state's qualifications to be a PACE provider and evidence of state plan amendment to implement PACE;

- Evidence of program's capability to meet all state and federal data and financial reporting requirements;

- Budget for program's first three years of operations with evidence that program will achieve financial break-even;

- Assurances that program has sufficient start-up capital to support program deficits in first two to three years of operations; and

- Indicators of fiscal soundness and an insolvency plan (such plan should address funds for periodic operational deficits related to variations in utilization of services as well as an insolvency reserve);

- Completion of the Medicare Part D application and approval of the actuarially-certified premium proposals for dual eligible and Medicare only participants;

VI. TIME LINE FOR THE DEVELOPMENT OF PACE IN FAIRFAX

The table below is designed to give an absolute best-case scenario time line for PACE development in Fairfax. Start-up periods are usually at least eighteen (18) months and in many cases have stretched to three years or longer depending on certain factors. This particular time line is extremely aggressive considering activities and decisions to date by the stakeholder group, however this time line can easily be modified to account for any delays in the development process.

May - December 2008	• Make group stakeholder decision to proceed or not proceed with PACE in Fairfax; • Continue communication with DMAS and obtain support to pursue PACE development; finalize feasibility study and financial proforma; • Apply for $250,000 PACE start-up grant through DMAS (if available); • Determine and establish PACE organizational and governance structure; • Determine sources of financing to cover PACE start-up expenses; • Determine location of PACE Center; • Begin working on draft PACE application and submit to draft to DMAS (last quarter of 2008)
January – March 2009	• Begin any capital improvements necessary to the PACE Center (impacts operational time frame dramatically); • Work with DMAS to edit provider application and finalize for submission to CMS; • Secure Medicare Part D premium proposals through Milliman; • Complete Medicare Part D application;
April 2009	• Submit PACE provider application for PACE to CMS: 1st 90 day clock starts; • Submit Medicare Part D application; • Formal provider network activities begin; • Facility renovations continue;
July 2009	• First 90-day clock ends; • Request for Additional Information (RAI) received from CMS; • Facility renovations completed in time for State Readiness Review;
August – October 2009	• RAI completed, reviewed by DMAS, and submitted to CMS; • State Readiness Review of PACE Center completed by DMAS;

October – December 2009 January – March 2010	• Second 90-day clock for provider application begins at CMS; • Final review of application by CMS; • Application approved; • Program agreement signed; • Begin operations as a PACE program

The ability of PACE applicants to locate, renovate, and have the PACE Center ready to deliver PACE services will greatly impact any time line. DMAS has determined that PACE Centers be licensed as adult day care. Other issues such as local building code standards should be explored during the PACE Center site selection process. PACE applicants will also need to begin developing a provider network for those services that will not be provided directly by the PACE organization and continue routine communication with DMAS during the development process.

VII. PACE Development and Service Delivery

Organizational Structure and Governance

PACE may be organizationally placed as part of an existing provider such as a direct department of the hospital or as a related corporate entity. Or a group of potential providers may enter into an affiliation agreement or joint venture. The only organizational requirement is that the program or sponsoring organization be a 501(c)(3) non-profit tax-exempt organization. The organizational placement decision is often made on the basis of insulating the financial risk a health care provider may be exposed to both during start up and through ongoing program operations. PACE programs, with enrollments typically averaging 300 to 400 participants, have been extremely successful in managing the health care needs of enrollees which allows the alignment of clinical outcomes with sufficient financial outcomes to maintain fiscal solvency.

In addition it should be noted that unlike Medicare Advantage regulatory requirements, PACE programs can elect to cease program operations with a 90 day phase down period. While certainly not a decision to be made lightly, it should be noted by Boards and leaders of organizations interested in PACE development that should the program prove to be unsuccessful the financial risk to the provider or sponsoring provider can be mitigated with in a reasonably short period of time.

Regardless of organizational structure, a governing body must be established to perform the following regulatory responsibilities.

- the governance and operation of the organization;
- the management and provision of all services, including the management of contractors;
- the Quality Assurance and Performance Improvement (QAPI) program;
- all policies and procedures; and,
- financial performance

The establishment of a Participant Advisory Council (PAC) is also required by the federal PACE regulation to provide consumer and community input into the operations of the program.

Over the last several months, the stakeholders have agreed to collectively pursue PACE in some capacity. In order to provide some structure for decision making, it is recommended that a formal agreement between the organizations be established. This agreement should appoint individuals from each provider who will be empowered to make decisions related to the development of PACE. It should also include the ability of designated representatives to allocate the resources of their entities that will be needed during the feasibility and development phase. This would provide some organizational structure and decision making capacity that is necessary to move the pursuit of PACE forward.

An organizational strategy that should be considered by the stakeholder group is a joint venture or limited liability arrangement. These types of arrangements have been employed as the development strategy for several PACE organizations. The collaborative approach allows

organizations an avenue to have a vested interest in the PACE organization but somewhat limits the financial risk of PACE to the parent corporation and allows the pooling of funds and resources of multiple organizations to cover capital and working capital expenses. If this option is pursued, the sponsoring organizations must be determined, the organizational structure established, and 501(c)(3) not-for-profit status secured.

Financial Implications

The expenses associated with providing care for this very high cost population must be monitored closely in order to maintain fiscal viability. Effective management of inpatient care will be essential in order to successfully manage financial risk. To date, no PACE program has been closed due to lack of financial solvency. PACE programs have successfully managed care by proactively addressing the needs of participants through the interdisciplinary team approach to care. The PACE organization, as a requirement of the PACE provider application, will be required to cover all financial losses of the program until it reaches financial break-even and provide assurance that it can cover the expenses of the program for one month in the event of insolvency.

Marketing Strategy

Marketing plans should be strategically designed to attract and enroll as many PACE participants as possible. A comprehensive marketing strategy and implementation plan must be in place and receive constant attention. The intake process must be managed and cultivated to maximize the satisfaction of referral sources, potential participants, and their caregivers. In general, PACE organizations should attempt to initiate operations with at least eight (8) participants and seek to grow by five (5) or more participants per month. As the program matures, census attrition will inevitably occur via death and disenrollment; net census growth must account for census attrition.

Equally important to the marketing plan is the development of corresponding marketing materials. Marketing materials cover a host of information and should be professionally developed in order to communicate PACE attributes to potential enrollees and referral sources. Glossy brochures, print ads, and radio and television spots are some strategies that have been incorporated by existing PACE programs. DMAS and CMS must approve all marketing materials prior to their use and distribution.

Due to the concerns that the Fairfax market may not have sufficient dual eligibles to develop a fiscally sound PACE program, it is imperative that the sponsoring organizations of PACE understand their obligation to provide referrals that will result in PACE enrollees. During the feasibility and development stages, a more in-depth review to determine the potential market is needed.

PACE Center

The PACE Center is the focal point of service delivery for the PACE program and is usually the largest capital outlay associated with beginning a PACE program. The center must be designed, constructed, equipped, and maintained to provide for the physical safety of participants, staff, and visitors. The PACE Center must provide a functional, accessible, and comfortable environment for the delivery of services that protects the dignity and privacy of participants and contain space for a

primary care clinic, rehabilitation services such as physical therapy, occupational therapy, and speech therapy, recreational activities and meals, and a courtyard area for outside activities.

Selecting an appropriate PACE site for the PACE Center involves a number of critical factors that must be considered by developing PACE organizations. Ideally, the PACE Center should be located in an area of the community that is familiar to those who will be served. The actual location should be based on an analysis of the intended service area, the number of PACE eligibles, and where eligibles live. Such a location supports census building efforts and eases the burden of transportation. Transportation to and from the participant's residence to the PACE Center should be no more than 35-40 minutes.

A PACE Center typically serves from 125 to 175 participants with an average daily attendance of 75 to 110 participants. On average, each participant will attend the PACE Center two to three days per week. Because PACE must provide transportation to and from the PACE Center on a daily basis and also to medical appointments in the community, the program must have enough vans and drivers who are responsive to the needs of the participants. As with PACE Center services, the most control in providing transportation results from having drivers on staff and having vehicles for PACE program use only. Some PACE sites contract for this service initially and move to direct provision as census grows.

Typically, the size of a PACE Center is 10,000 to 20,000 square feet. A 15,000 square foot PACE Center would be able to serve a census of up to 175 with an average daily attendance of around 100-110. It is important to note that the size of the PACE Center should accommodate the projected census and anticipated daily attendance. As census grows and PACE Center capacity is reached, additional PACE Centers may need to be developed.

Primary Care

Because primary care in PACE is integrated with day-to-day PACE center operations, the PACE program will need to have within its PACE Center(s) the physical and operational capacity to function much like a physician's office. Optimally, the program's physicians will focus exclusively on the needs of the enrollees in the PACE program. Participants should know their physician and see them routinely for care. Continuity of care between the PACE Center, hospital, and nursing home should always be maintained. The delivery of primary care in the PACE model has several features:

- The physician is the primary care provider for all health care and the gatekeeper for specialty services and inpatient care;
- Nurse practitioners can be used to supplement and expand primary care;
- Under the direction of the primary care physician, nurses often assess acute situations in the PACE Center and initiate treatment;
- Sophisticated assessment techniques are used in the PACE Center, e.g., EKGs and screening lab work;
- Clinic procedures are needed with guidelines for routine and episodic work;

- If hospital care is required, the PACE physician admits and manages all aspects of hospital care, including the involvement of medical specialists, and coordinates discharge back into the community in conjunction with the IDT;
- If nursing home placement is required, the physician continues to manage the participant's care in the nursing home.

Capital Hospice has physicians who provide end of life and palliative care similar to care provided in PACE and could be a great resource in the recruitment of primary care staff for PACE.

In-Home Services

To manage in-home care needs, PACE staff will assess all enrollees in their homes and have access to flexible, responsive personal care services. Since in-home services are authorized by the Interdisciplniary Team (IDT), the IDT must learn to balance center attendance with in-home care. Characteristics of an effective in-home services component include:

- Availability seven days a week;
- Control and communication through the team with consistent feedback to team;
- Ability to initiate services the same day as requested;
- High quality services with monthly on-site staff supervision; and,
- Low staff turnover.

Ultimately, as with PACE Center services and transportation, the greatest control and accountability for in-home care is achieved through direct provision. Direct provision benefits include:

- information and feedback to the team about the home situation;
- more ability to be flexible based on the needs of the participants;
- team ownership of the treatment plan;
- extension of team resources into the home;
- understanding by home care workers of the model and the team's concerns; and,
- decreased administrative costs for contracted services.

Service Integration

The IDT is the mechanism through which PACE services are integrated. When an individual becomes a PACE enrollee the IDT assumes all case management authority for the enrollee, decides on treatment plans, authorizes the delivery of services, and coordinates PACE Center services with primary and in-home care. The intensity and complexity of service needed as well as the open-ended length of stay for program enrollees will pose special challenges for the IDT. As census grows, so must the size of the PACE Center staff. The addition of staff brings with it new work styles, personalities, and values, all of which need to be managed to develop and maintain an effective IDT.

The PACE service-delivery model creates a level of decision-making which may be unfamiliar to many health care professionals when they begin to serve as PACE IDT members. In addition to the typical case management activities of determining the number of days of center attendance or the number of home care hours to approve, the team will face:

- Evaluation of trade-offs between "quality" of life and "quantity" of life;
- The challenge of keeping the family involved as partners in the care plan;
- Decisions on the use of extensive versus maintenance rehabilitative services;
- Development of guidelines for nursing home placement and assessing when the participant no longer benefits from continued community residence;
- Judging when to add, reduce, or discontinue any given service to maximize independence;
- Ethical issues and underlying principles in decision-making involving the frail elderly.

The significant service development challenges related to operating PACE successfully will be the development of the primary care component; management the acute care risk, and building an IDT capable of integrating all Medicare and Medicaid services.

Data Collection and Medical Records

An all-inclusive medical record is maintained for each PACE enrollee. Care across all levels of service is consolidated into one central medical record. Data collection related to service utilization, socio-demographics, diagnoses, enrollment, and disenrollment must be collected and submitted to DMAS and CMS. Capital for computers and information systems will be necessary to comply with all reporting requirements and to assist with scheduling and care coordination.

Health Plan Functions

PACE is generally sponsored by a health care provider verses a managed care entity. As a hybrid of both, the importance of the health plan functions such as enrollment, disenrollment, submission of diagnostic information that impacts the Medicare rate and most importantly the submission of prescription drug event data as required by Medicare Part D add a level of complexity to operational requirements. Software claims processing systems and data systems must either be provided directly or subcontracted to other providers who function as third party administrators. Due to the demand of the types of “back office” functions required of PACE programs, the National PACE Association is currently exploring options to assist small PACE programs and those in start up phases to access these services. This impact on program revenue makes this a key issue for discussion in the planning and development phase.

Quality Assurance and Performance Improvement

An extensive quality assurance program is a requirement of the PACE program. Specific performance indicators have been defined by CMS and the PACE program will be required to submit quarterly reports to CMS. The Quality Assurance and Performance Improvement (QAPI) program is implemented under the direction of the PACE Medical Director. The resources of an

Ethics Committee, a Medical Advisory Committee, and a Quality Assurance Committee at each PACE Center should be utilized to assure that the best care possible is provided to participants. The involvement of the community in these committees allows the program to draw upon community resources and build strong working relationships with churches, community leaders, and other long-term care providers. Once the program is developed it can serve as a training site for health care professionals.

PACE and Senior Housing

A significant portion of senior housing residents in HUD facilities may meet the age, financial, and clinical eligibility requirements for enrollment in a PACE program.

PACE eligibility criteria match up well with some of the most common characteristics of the elderly residing in HUD senior housing facilities. For example:

- Most senior housing requires the resident to be 62 or older, seven years older than the minimum age for PACE enrollment.

- Seniors in HUD housing facilities have a disproportionately high number of physical and functional disabilities indicating a higher likelihood that they would meet the state's clinical and functional criteria for nursing home level of care.

- A typical income limit for senior housing residents is 50% of the Annual Median Income (AMI) which is comparable to the 300% of the social security income (SSI) limit of about $20,000 for the Medicaid program.

- Asset tests for low income housing are set by the Department of Housing and Urban Development (HUD) nationally while these tests are set by each state for Medicaid eligibility. Both HUD and most states allow for the retention of some assets. In the case of HUD this allowance covers "necessary personal property" while for Medicaid the allowance is for the residence of a spouse or certain other dependents. While some HUD programs do not have an asset test, HUD calculates an imputed annual income based on two percent of assets valued over $5,000.

For PACE providers collaboration with senior housing provides an opportunity to ensure suitable and affordable housing as well as the opportunity to:

- lease or own suitable space in or adjacent to the senior housing facility for PACE centers or a subset of PACE services;

- increase community visibility for marketing efforts; and

- reduce transportation and operational costs.

From a housing perspective, collaboration with PACE provides an opportunity to address the care and service needs of aging residents without the housing sponsor's direct involvement in service delivery (and therefore not needing to be licensed or certified).

A significant portion of senior housing residents in some housing facilities, particularly older facilities, may meet the age, financial and clinical eligibility requirements for enrollment in a PACE program. PACE participants must be over the age of 55 and meet their state's nursing home level of care criteria. Also, though not a requirement for PACE, over 90% of PACE participants qualify for Medicaid coverage. Since PACE participants must be certified by the state to be nursing home eligible, only a portion of a senior housing facility's residents would be able to enroll in PACE. While it will vary from market to market, it is estimated that about 20-30 percent of older persons in federally assisted senior housing are dependent in three or more ADLs, and therefore at risk of moving to a facility that provides a higher level of care (e.g., nursing home). The number of frail elderly generally will be higher in older buildings where residents have aged in place rather than in more recent developments where the move-in age is younger.

Of the 20-30% that could enroll in PACE, only a subset will actually choose to do so. Therefore, it is assumed that it is more likely that as many as 15-20% of senior residents would enroll in PACE. Applying this more conservative estimate to the total number of senior housing residents in the three service areas studied provides the following estimates of potential enrollment impact:

Fairfax – 37 facilities with 4,598 units = 690 to 920 potential participants

This potential pool of PACE eligibles could be significant in the Fairfax market where there is uncertainty by the stakeholders as to the viability of the market. As PACE development proceeds, it will be important to begin communication with housing providers to raise awareness about PACE.

XIII. PACE MARKET ANALYSIS

A critical step in assessing PACE feasibility involves determining the potential market for PACE enrollment based on a projected number of PACE eligibles. Based on national PACE program experience, most providers can anticipate a conservative market penetration of 5-10% of potential eligibles that would enroll in a PACE program. This can vary dramatically depending on other community services that may be available, Medicaid financial eligibility for PACE enrollment, and travel time to the PACE Center. Understanding the local long-term care market is a critical success factor for any potential PACE provider.

This demographic market analysis determines the number of potential PACE eligibles in the Fairfax service area by focusing on three primary data sets:

(1) Age: total households age 65 and over,

(2) Medicaid eligibility: total households age 65 and over with household income less than $15,000, and,

(3) Clinical eligibility: an estimate of those persons age 65 and over who would self-report at least one self-care limitation and at least one mobility limitation.

For purposes of this analysis, age focuses on those persons and households that are 65 years of age and older. While PACE eligibility technically begins at age 55, national PACE experience has demonstrated that most persons that enroll in PACE are 65 years of age and over, primarily due to the fact that 65 years of age is when Medicare eligibility is attained for most beneficiaries. Although Medicaid eligibility is not an eligibility requirement for enrollment in PACE, currently the majority of PACE enrollees are eligible for both Medicare and Medicaid. Those ineligible for Medicaid must pay the monthly Medicaid capitation privately, which many potential enrollees view as cost prohibitive in many PACE markets. Therefore, this analysis focuses on a low-income population - those individuals who are currently Medicaid eligible or those who are likely to spend down quickly to meet financial eligibility criteria. Since DMAS requires PACE to meet the same financial eligibility requirements as home and community based waivers, 165% of SSI ($15,000 or less) was used to estimate Medicaid financial eligibility.

The clinical eligibility category is determined based on the self-reported health status of persons living in the defined geographic area(s). U.S Census Bureau estimates for 2008 provide information on persons aged 65+ whom self-report mobility and self-care limitations. Although such reporting does not ensure that these individuals will meet Virginia's criteria for nursing home placement, it does represent a reasonable proxy for nursing home eligibility. Because PACE most often enrolls a low-income population where the likelihood of poor health and functional impairment is greater than among the older population in general, an approach which uses these data results in a moderately conservative estimate of the actual number of frail elderly in the targeted geographic area. The two categories that are used in the final analysis to calculate PACE eligible estimates:

- Self Reported, *2+ADL limitations, including at least one self–care*; this category results in the most conservative estimate for PACE eligibility in a given service area;

- Self Reported, *Go Outside the Home limitation*; this category results in the most aggressive estimate for PACE eligibility in a given service area;

Please refer to Appendix D for detailed demographic PACE eligible tables (conservative and aggressive) for the Fairfax market which are summarized in the tables below.

Estimated PACE Eligibles
Fairfax Service Area
Conservative Estimate

	65+ Non-Institutionalized	65+ Households	65+ Households, less than $20,000 Annual HH Income	65+, 2+ADL's (Estimated Clinically Eligible)	Estimated PACE Eligible Households
Fairfax	**92,037**	**66,854**	**8,173**	**9,720**	**1,274**

Estimated PACE Eligibles
Fairfax Service Area
Aggressive Estimate

	65+ Non-Institutionalized	65+ Households	65+ Households, less than $20,000 Annual HH Income	65+, Go Outside the Home Disability (Estimated Clinically Eligible)	Estimated PACE Eligible Households
Fairfax	**92,037**	**66,854**	**8,173**	**21,425**	**2,817**

It is not only important to know how many PACE eligibles are located in potential PACE service areas but also to know where the potential participants live. Please refer to Appendix E for a color-coded density map of PACE eligibles in the Fairfax market based on the conservative estimate.

General market conclusions:

- Based on conservative clinical eligibility estimates, Fairfax market is estimated to have approximately 1274 PACE eligibles;
- 1274 PACE eligibles is an average market by PACE standards, but in this highly urbanized market is significantly less than would normally be anticipated. Estimates based on census data alone are likely conservative and may not reflect the true need of the market;

- The most PACE eligibles are located in Fairfax County (811 PACE eligibles);
- The service area could be typically served by a single PACE Center but considering the density of the market and the issues with transportation one PACE center may not be an efficient model. Concepts such as a hub-spoke model may be needed to ultimately serve the entire proposed catchment area effectively.
- Source: US Census Bureau 2008 Estimates

Only 444 square miles, this market contains a significant number of PACE eligibles (1,274) as well as a high ratio of PACE eligibles per square mile (2.8). As a suburb of Washington D.C., this highly urban market is representative of a traditional PACE service delivery area. Fairfax County and Fairfax City comprise around 80% of the square miles of the total service area and 821 of the 1,274 total PACE eligibles. Arlington County (267 PACE eligibles), Alexandria City (173 PACE eligibles) and Falls Church City (13 PACE eligibles) also have potential PACE eligibles.

Statistical demographic market evaluation is only one component of a complete PACE market assessment. Internal and external competitive factors and provider knowledge of local markets and the long-term care network are also critical factors that complete a PACE market assessment. The analysis is most beneficial at the macro or aggregative level and has significant limitations when applied to a very specific market segment. This is especially true when applied to geographies with smaller population bases where broad analysis may not fully capture the nuances of the market. The methodology in this analysis provides a broad estimate of whether a population base for program development exists. A more in depth analysis should be conducted to determine whether the population base identified in more specific markets would actually enroll in the program.

Private Pay Market

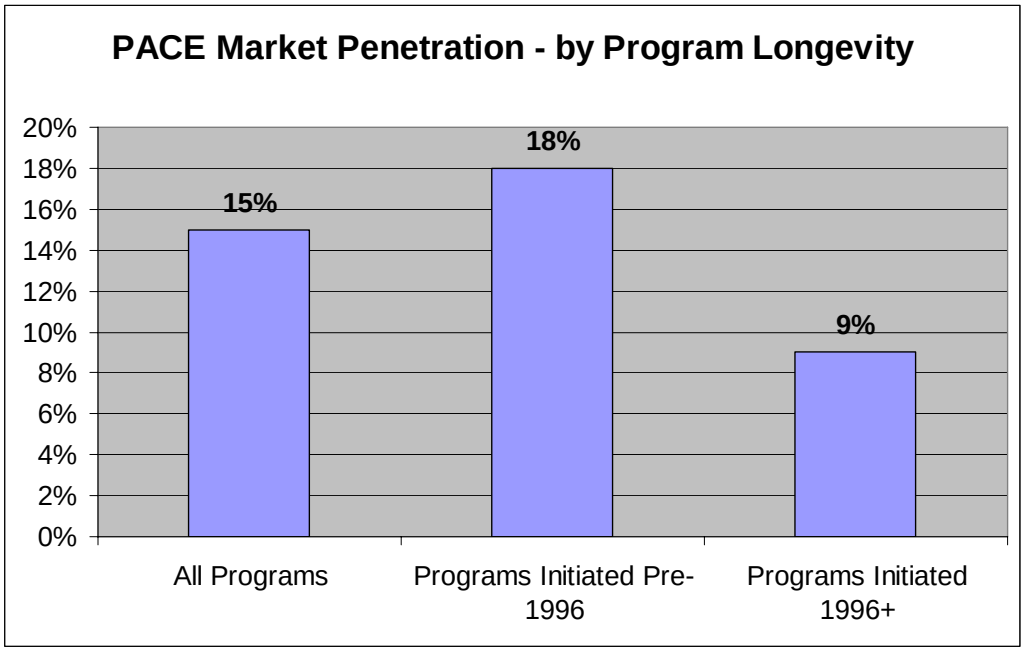
In order to have a financially solvent PACE program in Fairfax, the ability to market the program to a private pay market should be evaluated. In PACE, private pay refers to an individual who is eligible for Medicare and not Medicaid, the traditional payer sources for PACE enrollment. A person eligible for Medicare but not Medicaid who enrolls in PACE would be required to privately pay the PACE organization what is equal to the Medicaid monthly capitation payment. PACE's success nationally with the private pay market has been minimal. A more affluent population often elects to access health care services through other sources. The feasibility of capturing a private pay market should not be ruled out in spite of limited success. In order to make the assumption that a PACE program in this area can successfully enroll this market, a link with other formal services such as housing is necessary. The potential relationship with Little River Glenn offers an excellent opportunity to test if PACE can enroll a private pay market.

Note: The impact of Medicare Part D on PACE and the private pay market has not been fully determined nationally. PACE Programs are required to develop a premium proposal to provide the Medicare Part D benefit. Since PACE by federal statute can charge no co-pays or deductibles the premiums for PACE programs are often in the $500 to $600 a month range. This premium is paid by the individual who is not Medicaid eligible. In addition the potential enrollee must privately pay

what is equal to the Medicaid benefit for the long term care component of PACE. Together these monthly fees may be too burdensome for a potential enrollee when they must also maintain their housing in order to remain in the community. The cost of housing in the Fairfax market may well negatively impact the ability to locate and enroll a private pay market.

Market Penetration

Targeted populations within high penetration zip codes support the start-up census and net monthly enrollment statistics as described within the financial proforma. The table below reflects current market penetration rates for all PACE programs, programs started before 1996, and programs started since 1996.



As the table above indicates, PACE programs nationally, average approximately a 15% market penetration rate. Programs that have started since 1996 have achieved a 9% market penetration rate. It should be noted that many of these programs have yet to reach their full market potential. If PACE is able to achieve a modest 9 % market penetration rate in the primary market (see table below), the result would be a PACE program with almost 115 participants. A 15% market penetration rate in the primary market (see table below) will result in a PACE program with 191 participants.

The table below reflects 124 enrollees to be an attainable goal based on the estimated size of the PACE eligible market.

Market Penetration Measures for Fairfax PACE Primary Market

Estimated PACE Eligible Base (Clinically Eligible and Financially Eligible for Medicaid)	1274
To achieve an enrollment of:	The penetration of the PACE eligible base would need to be:
100 Enrollees	7.8%
124 Enrollees	9.7%
175 Enrollees	13.7%
200 Enrollees	15.7%
If the assumed demographic penetration is:	The expected PACE enrollment level would be:
5%	64
9%	115
15%	191

An aggressive marketing and enrollment strategy must be developed as a component of PACE start-up. The ability of a PACE program to market the program and ultimately enroll participants is dictated by a number of factors. These factors include:

- The success of the PACE intake and social work staff to develop, maintain, and foster relationships with the key long-term care referral sources in the community. Community-based providers, including physicians, social service agencies, and skilled home health service providers who currently serve the frail elderly in Fairfax should be developed as referral sources for PACE. Additional referral sources include hospital discharge offices, nursing homes, adult day care providers, and home and community based waiver programs.
- The success of PACE intake staff in working with the local agency that processes Medicaid clinical eligibility, and work to expedite the assessment process to the greatest extent possible. DMAS has delegated the determination of clinical eligibility to the local Department of Social Services (DSS) who uses the Uniform Assessment Instrument (UAI) to determine the potential enrollee meets the nursing home eligibility. It will be important to build an understanding and advocacy for the model with the case managers in DSS and with providers that are part of the local aging network. The enrollment step and frequent delays in determining Medicaid clinical and /or financial eligibility have had an impact on PACE program growth and market penetration in other markets. DMAS must be aware of the vulnerability of PACE with this enrollment process and collaborated with PACE to improve their understanding of the model and determining where PACE fits into other home and community based services the state offers.
- The success of the Medical Director and PACE physician(s) to educate the local physician community about the PACE program, who the program is suited for, and the benefits of enrollment in the PACE program. Because all PACE participants receive their medical care from the PACE staff physician the issue of how physicians in the community will

perceive the program may arise. It is highly recommended that the future PACE Medical Director play an active role in describing the program to community physicians.

- Organizations developing PACE must develop a marketing plan and build a strong network of referrals to ensure that potential participants are presented with PACE as a long-term care option. The capacity to build program census is in part a function of the competitive environment in which PACE is located and the ability of the program to develop such a referral base.

External Market Issues

PACE organizations thrive in markets with high demand for their services. This is largely a function of the total size population that the organization would serve the availability of service alternatives and the desirability of those services. With sufficient demand, PACE programs that are well integrated into the community are in the best position to achieve high levels of enrollment. The program's ability to successfully serve the population it enrolls will depend on its structure, the governance established for it and the team of key staff that will lead its development.

An assessment of current nursing home beds and assisted living units in the Fairfax market reveal the following:

Nursing Home Beds	
Alexandria City	566 Beds
Arlington County	663 Beds
Fairfax City	327 Beds
Fairfax County	387 Beds
Total	*1943 Beds*

Assisted Living Units	
Alexandria City	47 Units
Arlington County	57 Units
Fairfax County	56 Units
Total	*160 units*

Market Assessment Conclusion

In summary, the target population for PACE consists of older individuals (age 65+) who are living in the community, sufficiently frail enough to be nursing home eligible, and Medicaid eligible. For 2008, this target population is conservatively estimated to be 1274 PACE eligible persons in the Fairfax market. While the numbers reflect an adequate number of PACE eligibles, they are not highly concentrated in one specific area or zip code but rather spread over a large geographical area that is densely populated. Traffic and transportation are barriers that will impact the efficiency of providing PACE services. In addition, antidotal information from the providers indicate there are large numbers of illegal immigrants who need long term care services but may not be financially eligible.

Key to PACE programs achieving enrollment targets is the process for the approval and verification that all PACE enrollees meet the state nursing home level of care requirements as established by DMAS. The cost of housing and the patient liability or share of cost that applies to Medicaid eligibles may also adversely impact those persons who meet the clinical and financial eligibility but can not afford to maintain a residence in the community and pay the patient liability Medicaid has determined they owe for enrollment in PACE. It should be noted that these same financial eligibility criteria apply to DMAS home and community based waiver. To the degree that these issues impact PACE they also impact the waiver program.

The stakeholder organizations are highly regarded by and extremely visible to colleagues, the community, and other health care providers in the Northern Virginia area. The importance of these attributes cannot be overstated when discussing the chances for success or failure of a PACE initiative. A PACE program in Fairfax will complement existing providers in the community by providing a community-based alternative to nursing home placement once individuals can no longer be managed in home care and community settings alone. Significant efforts should be made to differentiate PACE from other community long-term care providers, highlighting PACE's focus as a medical model. A Fairfax PACE organization must also work with other community long-term care providers and successfully communicate PACE's role in the continuum of community-based options.

IX. FAIRFAX PACE FINANCIAL PROFORMA

Fairfax's start-up and five-year PACE financial proforma is based on conservative assumptions taking in to consideration anticipated census, revenue, utilization patterns, and corresponding expenses related to operating a PACE program in Fairfax. The proforma includes a start-up period of eighteen (18) months and five (5) years of operations. The start-up period begins on July 1, 2008 and ends December 31, 2009. The first month of operations with enrollees is projected to be January 2010.

The Fairfax financial pro forma projects future performance for one PACE Center with enrollment capped at 124 participants. There is certainly the possibility for future expansion of the program through the addition of one or more PACE Centers in the existing service area; *therefore, it should not be assumed that 124 participants is the maximum number of participants that can eventually be served by a Fairfax PACE program*. Additional PACE Centers will increase the census capacity of the program. Maximizing census takes advantage of economies of scale administratively and lowers the overall financial risk of the PACE organization.

Proforma assumptions should be considered conservative but may not materialize as projected. If census growth lags projections, revenue, net income, and cash flow estimates will likely not be realized and higher than projected financial losses may occur. Programs with lower census numbers (less than 150 participants) will be subject to much more financial volatility than larger programs (more than 150 participants) and will be more financially vulnerable to unexpected acute care and skilled nursing facility expense.

Some assumptions may change based on future decisions during the development process. The Fairfax proforma only serves as a baseline projection that does not take in to account likely unexpected expenses, fluctuations in census, or unanticipated increased staffing needs over the life of the program.

The table on the following page provides the Executive Summary for a Fairfax PACE program.

Fairfax PACE

Program of All-Inclusive Care (PACE)

Financial Proforma

Executive Summary

	Start-Up	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
Estimated Average Census		27	87	124	124	124
Estimated Year-End Census		59	124	124	124	124
Estimated Average Daily Attendance		16	52	74	74	74
Estimated Capital Expenses:						
Building/Renovation Expense**	$ 1,200,000	$ -	$ -	$ -	$ -	$ -
Equipment	100,000	10,000	10,000	10,000	10,000	10,000
IT	35,000	10,000	10,000	10,000	10,000	10,000
Vans (contract provider)	-	-	-	-	-	-
Estimated Total Capital	$ 1,335,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000
Estimated Net Operating Gain/Loss	$ (568,147)	$ (2,121,967)	$ (302,128)	$ 808,461	$ 693,927	$ 718,738
Estimated Operating Margin	-	-105.12%	-4.49%	8.25%	6.89%	6.95%
Estimated (Capital and Working Capital Cash Needs) /Cash Flow	$ (1,875,705)	$ (2,119,229)	$ (360,545)	$ 825,003	$ 726,585	$ 704,243
Net Gains/Losses	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
Equity Transfer/Other Changes in Unrestricted Net Assets	-	-	-	-	-	-
Changes in Assets/Liabilities	27,442	22,738	(38,417)	36,541	52,657	5,505
Acquistion of Land Buildings & Equipment	(1,335,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)
Estimated Line of Credit, Cash, or Loan Required to Meet Cash Needs, Maintain $300,000 in Cash Reserves, and Meet CMS Risk Reserve Requirements	$ 2,000,000	$ 2,400,000	$ 850,000	$ -	$ -	$ -
Other Debt Financing	-	-	-	-	-	-
Equity Contributions	-	-	-	-	-	-
Restricted Contributions	-	-	-	-	-	-
Partner Contributions	-	-	-	-	-	-
Estimated CMS Risk Reserve Requirement	N/A	$ 471,064	$ 1,064,234	$ 1,176,030	$ 1,224,828	$ 1,261,992
Estimated PACE Cash, Reserves, and Investments (including Line of Credit)	$ 124,295	$ 494,866	$ 1,078,955	$ 1,203,424	1,269,309	1,264,351
CMS Risk Reserve Requirement Met		YES	YES	YES	YES	YES
Estimated Five (5) Year Internal Rate of Return						-11.26%

Detailed projections for the Fairfax PACE start-up and five year financial proforma can be found in:

Appendix F: Census, Utilization, and Capital Costs Assumptions
Appendix G: Personnel/Staffing Assumptions
Appendix H: Consolidated Annual Financial Statements

Start-Up Funding and CMS Risk Reserve Requirements

As with any new program, capital costs and start-up costs must be secured until the program reaches financial break-even. The financial proforma projects total start-up funding for a Fairfax PACE program to be approximately $4.3 million dollars. The $4.3 million covers expenses related to PACE Center acquisition/development/renovation, furniture, equipment, and enough cash to cover operational losses until the program reaches break-even.

PACE Center capital development expense:	$1,200,000
Equipment expense (movable, fixed, furniture, and fixtures):	$100,000
IT capital expense (computers, servers, etc.):	$35,000
Working Capital (operational expenses until cash break-even):	$2,960,000
	$4,295,000

CMS also requires PACE organizations maintain a "risk reserve" to cover program expenses should the PACE organization become insolvent. The federal PACE regulation mandates PACE organizations maintain a risk reserve sufficient to operate the program for a period of thirty (30) days in the event of insolvency. This requirement may be met through cash, a line of credit, or a letter of guarantee from a sponsoring organization. This financial proforma automatically calculates the required risk reserve amount on an annual basis (see proforma Executive Summary). During the PACE provider application process, the PACE organization must be able to provide assurance to DMAS and CMS that risk reserve requirements will be met and will be maintained throughout the life of the program.

Financial Proforma Assumptions – Census and Revenue

- Census is projected to grow to 59 participants by the end of Year 1 and to 124 participants by the end of Year 2; maximum projected census is 124 participants;

- Payer mix is projected to be 90% dual eligible (Medicare and Medicaid), 4% Medicaid Only eligible, 4% private pay (Medicare eligible), and 2 % End Stage Renal Disease (ESRD);

- PACE Center attendance is assumed to average 3.0 days per week per participant;

- Medicaid capitation rates are based on rates obtained from Virginia DMAS for the "Northern Virginia" region for FY 2008 and trended forward 4% annually (8% total by 2010) to account for inflationary adjustments; Medicaid capitation rates are trended forward annually 3% for the five years of operations;

- Medicare rates are based on the 2009 AAPCC rates for the Fairfax region accounting for all counties and municipalities that are included in the service area and then adjusted for fragility. In April of 2007, CMS announced changes in the methodology used to determine the risk scores for PACE. Based on the projected impact analyses shared by CMS with PACE organizations, when fully implemented in 2012, the revised frailty factors will reduce payments an average of 15% with some PACE organizations experiencing payment reductions of nearly 20%. In 2008, PACE organizations are facing payment reductions of approximately 4% on average as the revised factors are scheduled to comprise 25% of PACE organizations' frailty adjustment.

  note: for further information regarding the current Medicare Advantage and PACE rate setting methodology, please refer to Appendix I – Announcement of Calendar Year (CY) 2009 Medicare Advantage Rates and Medicare Advantage and Part D Payment Policies;

- The Medicare frailty adjuster is trended down incrementally from an average of 2.4 in Year 1 to 2.08 in Year 5 based on the information in the previous bullet;

- The combined Medicare Part D capitation rate is projected at $524.12 for Year 1 based on industry benchmarks and current data from operational PACE programs;

Financial Proforma Assumptions – Operations

- Salaries and the projected fringe benefit rate were primarily obtained from personnel at stakeholder organizations; salary projections are intended to be on the upper end of the projected range in order to attract quality staff;

- Staffing ratios are based on the experience of existing PACE providers and the experience of PHSC with start-up PACE organizations; it is likely there will be some fluctuations and staffing plans will be highly impacted by census growth and PACE Center attendance;

- The PACE Center is projected to be leased at a rate of $30 per square foot (triple net); the square footage of the PACE Center is projected at 15,000; no lease expense is projected during start-up; additional facility expense (undefined) is budgeted at $27,000 annually;

- Primary care will be provided by a staff physician and a nurse practitioner; on-call expense is projected at $132,000 annually in Year 1 and trended forward 3% annually;

- Medications will be obtained via a contracted pharmacy provider; a part-time pharmacist consultant will be retained through contract;

- Transportation services will not be directly provided; a contract provider will need to be identified;

- Acute care utilization is projected to begin at an average of 3.4 days per participant per year in Year 1 and incrementally reduced to 2.4 days by Year 5; projected expense for inpatient hospitalization (medical/surgical, ICU, sub-acute) is projected to average $2,000 per day in

Year 1 and trended forwarded 3% annually; projected acute care expense was obtained from Inova; no reinsurance expense is projected;

- Skilled nursing facility (SNF) utilization is projected to begin at 1% of total capitation days in Year 1 and to incrementally increase to 7% by Year 5; projected expense for a SNF day is $200 based on estimates provided by the stakeholder group; projected SNF expense is trended forward 3% annually;

- Utilization for ancillary services such as laboratory services and radiology, outpatient services, routine specialists are all contracted and utilization and expense projections are based on the expectation that the Fairfax PACE organization will have utilization in line with PACE organizations nationally;

- Administrative expenses such as office supplies, travel, communications, insurance (including malpractice), marketing, information technology, consulting fees and other contracted services, National PACE Association dues, and Part D bid preparation by Milliman are all accounted for;

- Interest expense is projected at a low of $160,000 in Year 1 to a high of $262,500 in Year 3;

- There is no allocation for corporate overhead;

Financial Proforma Assumptions – Capital

- Renovation expense for the PACE Center is projected at $1.2 million based on an $80 per foot renovation expense on 15,000 square feet;

- Equipment expense is projected at $100,000; this amount is much lower than current experience and is made under the assumption that much of the equipment, furniture, etc. will be donated or purchased at a significant discount;

- Information technology capital is projected at $35,000; this amount is lower than current experience and is made under the assumption that this equipment will be provided in-kind or purchased at a significant discount;

- Depreciation follows a straight line schedule based on industry standards;

- Replacement equipment is accounted for based on the established depreciation schedule

PHSC relied heavily on current PACE program utilization statistics from across the country to develop the baseline assumptions related to operations. PHSC also has the advantage of operating its own PACE program to better understand operational trends and develop sound and reliable assumptions for program start-up. Like census, service utilization can have a significant financial impact on PACE programs. The best protection against financial risk is a skilled well-functioning IDT with the capacity to provide services in the community. Some variations in utilization should be expected from year to year,

particularly while the interdisciplinary team is gaining skills in managing this high utilization population.

Financial Proforma – Financing

- Overall capital and working capital needs for a Fairfax PACE program are projected at just under $4.3 million; financing is currently assumed as a loan or line of credit; projected cash needs are as follows:

  Start-up: $2.0 million
  Year 1: $2.4 million
  Year 2: $850,000

- Line of credit/loan projections include coverage for the CMS risk reserve requirement and the maintenance of $300,000 in cash at all times;

- The projected interest rate on the line of credit/loan is 5% over the life of the loan;

- Payback of the loan principal begins in Year 3 ($800,000) and continues to Year 4 ($750,000) and Year 5 ($800,000); the loan balance is projected to stand at $2.9 million at the end of Year 5;

- Capitalizing PACE start-up by other means may significantly affect the overall proforma projections;

Financial Proforma – Overview

- PACE program capital and working capital needs are projected at just under $4.3 million; line of credit/loan projections are $5.25 million;

- Program break even is projected in month 21 of operations at 100 participants; census is capped at 124 participants which is achieved by the end of Year 2;

- Year 5 projects a 6.95% operating margin with a positive cash flow of over $700,000;

- The estimated Five Year Internal Rate of Return is -11.26%;

X. SUMMARY AND RECOMMENDATIONS

Interest in the development of PACE in the Fairfax market has been sporadically pursued for several years. Reservations about the viability of the market have been of utmost concern to interested providers and the County. A more concentrated effort lead by Fairfax County has recently resulted in a strong group of experienced providers who have expressed interest in aggressively pursuing PACE development in this market. These agencies, Birmingham Green, Capital Hospice, Evergreen Home Care, Goodwin House, and the Korean Senior Center have emerged as the leadership group to move forward. It is clear that each of these stakeholder organizations have missions and values that support reaching out to at-risk and needy populations and a clear, strong commitment to serve such populations in the Fairfax market. The stakeholder group has strong leadership that support the concept and mission of PACE and embraces the need to provide care for frail elderly populations and to promote independence and quality of life in a cost-effective manner.

The Fairfax market also has very advantageous Medicare and Medicaid capitation rates and a state that embraces the PACE model as a building block for community-based long term care. The leadership of Fairfax County, the support of PACE as a statewide strategy by DMAS, the possibility of a state grant to assist with development costs, a higher comfort level by the providers looking at PACE, and the depth of experience of the interested providers create a unique opportunity for PACE development in Fairfax.

However, there are several unanswered questions and issues that should be addressed prior to moving forward in a formal capacity:

1) What organizational vehicle will serve as the 501(c)(3) not-for-profit entity that will function as the PACE organization? Will the current stakeholder organizations establish a formal partnership through a separate 501(c)(3) not-for-profit entity? What will the governance structure of the PACE organization look like? The ability to make decisions rapidly will be an important factor in how long it takes to operationalize a PACE program.

2) Which stakeholder or stakeholder representative will take a leadership role in moving the Fairfax PACE initiative forward? How will this decision be made and formalized by the stakeholder group?

3) What is the desired role of each of the stakeholders? Do certain stakeholders wish to be insulated from financial risk and serve only as contracted providers to the PACE organization? Are stakeholder governing bodies willing to assume the financial risk that PACE presents?

4) How will PACE start-up expenses be capitalized? While there are several stakeholder organizations at the table discussing a Fairfax PACE program, no decision or recommendations have been presented that address the financing requirements for PACE start-up and the CMS risk reserve requirement. Projected total expenses for a Fairfax PACE program prior to break-even are expected to be over $4 million.

5) Where will the PACE Center be located? Will the PACE Center be housed in existing space of one of the stakeholder organizations or will 'new' space be sought? Several options for the location of the PACE Center have been discussed but no consensus has been reached. This is a critical decision that will have an impact on many other decisions involved with start-up.

6) How comfortable are the stakeholders that the Fairfax long-term care market is strong enough to support a PACE program with a census of at least 124 participants? A component of this population is immigrant and may not qualify for Medicare and Medicaid services. Currently the County and other local public agencies are financing long-term care for this population.

7) Will a Fairfax PACE program be able to penetrate a private pay market? Does PACE viability hinge on the ability to penetrate the private pay market to a degree that is significantly higher than has been experienced by PACE programs nationally?

8) Will DMAS grant funding ($250,000) be re-established for assistance with start-up expenses?

9) What is the future role of the County with regard to PACE? The County has been an invaluable resource during the PACE initiative and has funded and coordinated all PACE activities to date.

PHSC recommends the following activities, both internal and external, for the current stakeholder group as the next step for this initiative to more forward:

Internal:

- Review this report as a stakeholder group and as individual stakeholders and make a decision to move the initiative forward based on future viability; individual stakeholder organizations should make commitment to move forward and communicate to the group their desired role;

- Formalize the stakeholder group's leadership and decision-making process moving forward; define more specific roles for stakeholder members;

- Begin more detailed discussions regarding the organizational structure and governance of the future PACE organization;

- Begin more detailed discussions regarding how PACE start-up and operations until break-even will be financed currently and in the future; CMS risk reserve requirements must also be addressed and accounted for in a financing plan;

- Begin more detailed discussions regarding the location of the PACE Center;

External:

- Continue communications with DMAS and lobby for reinstatement of the $250,000 state PACE start-up and development grant for next year;

- Continue to work with the County and together define a role for the County moving forward;

Appendix A

CMS PACE Fact Sheet

PACE Fact Sheet

Contents:

GENERAL INFORMATION

PACE Definition

The PACE program is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

PACE Organizations

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing PACE services. The following characteristics also apply to a PACE organization. It must:

- have a governing board that includes community representation;
- be able to provide the complete service package regardless of frequency or duration of services;
- have a physical site to provide adult day services;
- have a defined service area;
- have safeguards against conflict of interest;
- have demonstrated fiscal soundness; and
- have a formal Participant Bill of Rights.

Publications, demographic information, and other statistics about the PACE program

The best source for PACE demographic information is the National PACE Association. You may call, write, or email the NPA at:

National PACE Association

801 N. Fairfax Street, Suite 309
Alexandria, VA 22314
(703) 535-1565

www.npaonline.org

Government listing of sanctioned providers

You may find this listing at http://www/dhhs.gov/progorg/oig/cumsan/main.htm .

PACE APPLICATION

Status of physical location prior to submitting an application

CMS does not require a PACE Organization’s building to be completed prior to submitting an application. However, for non-operational sites the building must be complete at the time of the State Readiness Review.

Signed inpatient contract requirements of non-operational Organizations

A letter of intent will suffice for the application, but a signed contract will be required to enter into a program agreement.

Application processing timeframe

While the circumstances contained in each application will be different, a conservative estimate of the average time needed to process a PACE application is nine months. Once CMS receives an application from the State, a determination will be made within two weeks on the completeness of the package. If the package is not complete, CMS will send a letter to the State and the applicant notifying them of this decision. If the package is complete, a letter will be sent to the State and applicant acknowledging that the application is acceptable.

CMS has up to 90 days (retroactive to the date a complete application was received in CMS' Central Office) to determine what additional information on the application is needed, if any. A letter requesting additional information will be sent to the State and the applicant. Once all the information submitted in response to the request for additional information (which includes the information from either the State's readiness review or CMS' onsite review) is received, the second and final 90 day clock will start. CMS will render a decision on the application within this second 90 day period, and if applicable, the three party Program Agreement will be signed.

Description of parent entity

The PACE applicant should provide information on the PACE organization and its relationship to their corporate entity. This can be achieved by enclosing organizational charts of the entire health care system that the PACE organization is a part of. The organizational chart should show where the PACE organization relates to the other entities and the reporting structure from the governing body to the PACE organization.

Signature authority for State Assurance Page

The State Administering Agency or its designee must sign the State's assurances.

Identification of the potential property in relation to the "mean travel times" on the service map

CMS is requiring the prospective PACE organization to have an identified site before submitting an application, and reflect its location on the service area map in relation to the “mean travel times”.

Status of positions for which the application requires a position description
The positions for which the application must include a position description do not need to be filled prior to submitting a PACE application. We recognize that the PACE site may not be operational at the time the application is submitted. However, if a PACE applicant has been operational, as in the case of pre-PACE organizations, CMS would expect all the required positions to be filled in order to meet the needs of the organization's current participants. The application must include position descriptions for the PACE employees. Resumes should accompany the application for any staff hired. Letters of intent or employee agreements will be required before a program agreement can be signed.

Plan of care review during the application review process and during the onsite review
As part of the CMS review of the provider application, CMS will review a template of the provider's plan of care to ensure that it meets the requirements stipulated in the regulation. Then, during the onsite phase of the application review process, CMS will review the entire participant medical record to include all assessment data that were gathered and recorded to understand the participant's needs. Since the plan of care is based on the assessments of the team, the plan of care should reflect all of the participant's care needs. The review of the participant's medical record will be performed by experienced Registered Nurses at CMS.

PACE ELIGIBILITY

Eligibility criteria
To be eligible to be a PACE participant, you must be age 55 or older; meet a Nursing Facility level of care; and live in the PACE organization service area.

Age requirement
The age requirement in the PACE Protocol reads differently from the requirement in the Balanced Budget Act (BBA). While the Protocol states that PACE participants must be at least age 55, the BBA refers to age 55 or older. The BBA cannot be read to allow the age requirement to be set above age 55. In addition, there is a provision in section 460.150(b)(4) of the regulation that permits additional program-specific eligibility criteria to be imposed by a PACE organization and described in the program agreement. However, this provision further states that these additional conditions may not modify the requirements of paragraph (b)(1) and (b)(3) of this section. Therefore, stricter age requirements that would restrict eligibility to dually eligible beneficiaries may not be imposed.

Use of expanded Medicaid eligibility using home and community based service rules
Section 710 of the Omnibus Appropriations Act of 1998 permits States to cover PACE enrollees under institutional groups and rules similar to those that apply under home and community based services waivers. This means that States can elect to cover PACE enrollees under the special income level group (also known as the 300 percent group). States can also apply other institutional rules to PACE enrollees, such as spousal impoverishment and post-eligibility treatment of income.

PACE site serving only dually eligible beneficiaries to remain exempt from HMO licensure

Section 460.150(d) of the regulation specifically states that eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid recipient. A potential PACE enrollee may be, but is not required to be, any or all of the following: 1) entitled to Medicare Part A; 2) enrolled under Medicare Part B; or 3) eligible for Medicaid. This provision establishes the basic eligibility criteria for PACE participants and permits enrollment into the PACE program for individuals who are entitled to Medicare, eligible for Medicaid, or both, or neither. The above mentioned regulatory provision would prohibit a State or a PACE organization from serving only dual eligibles. Since the regulation does not require PACE organizations to be licensed as HMOs, CMS believes this is an issue that must be resolved by the States and the providers.

PACE SERVICES

Services provided through PACE

PACE services include, but are not limited to, all Medicare and Medicaid services. At a minimum, there are 16 additional services that a PACE organization must provide: e.g., social work, drugs, NF care. Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals.

Location of service provision

The service delivery settings include an adult day health center, home, and inpatient facilities.

Coverage of over-the-counter medications

Over-the-counter medications are covered under the PACE program if they are authorized by the PACE interdisciplinary team and are included in the participant's plan of care.

Provision of hospice care

Since comprehensive care is provided to PACE participants, those participants who need end-of-life care will receive the appropriate medical, pharmaceutical, and psychosocial services through the PACE organization. If the participant specifically wants to elect the hospice benefit from a certified hospice organization, then the participant must voluntarily disenroll from the PACE organization. The PACE organization would work with the State administering agency and CMS to facilitate the election of the hospice benefit.

Provision of mental health services

The PACE program is required to provide all health, medical and social services necessary to restore and preserve the participant's level of well-being. This includes mental health services. The organization can contract with mental health specialists to provide these services.

Composition of interdisciplinary team

At a minimum, the interdisciplinary team is composed of a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, PACE center supervisor, home care liaison, health workers/aids, or their representatives, and drivers or their representatives.

Employment status of interdisciplinary team members

There is no requirement that any member of the PACE interdisciplinary team be fulltime, or be employees of the PACE Organization. Consequently, the PACE Organization may hire staff on a part-time basis until the census is sufficient to support fulltime staff, or may enter into contracts for any member of the interdisciplinary team.

Frequency of interdisciplinary team meetings

The PACE interdisciplinary team must meet on a basis frequent enough to ensure that the comprehensive medical, health, and social needs of each participant is met. Generally, PACE teams meet daily to discuss the status of participants and recent events that may have occurred at the various locations where services are provided.

PACE ENROLLMENT

Enrollment process

Enrollment in the PACE program is voluntary. If a participant meets the eligibility requirements and elects PACE, an Enrollment Agreement is signed. This contains things such as participant demographic data, description of benefits, effective date, explanation of policy regarding premiums, emergency care, etc. Enrollment continues as long as desired by the PACE participant, regardless of change in health status, until death or voluntary or involuntary disenrollment.

Initial comprehensive assessment timeframe

The regulations state that the initial comprehensive assessment "must be completed promptly following enrollment." Though CMS has not specified a timeframe for completion of the initial comprehensive assessment, we believe that it should be completed within a few days of a participant's enrollment into the PACE program. This is to ensure that there is no delay in administering appropriate care to the participant. We have found that the initial assessments conducted by the PACE demonstration sites are often completed by the date of enrollment since a proposed care plan is often presented to the participant as part of the enrollment process.

Care provision between the time of signing the enrollment agreement and effective date of enrollment

According to §460.158 of the PACE regulation, "A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement." Between the signing of the enrollment agreement and its effective date, the PACE organization may elect to provide services to the newly signed enrollee. However, any services provided are not considered "PACE" services until the effective date of the enrollment. Therefore, services would only be covered to the extent the individual's existing health care coverage (e.g. Medicare FFS, Medicare Advantage, Medicaid Managed Care or Medicaid FFS) provides the coverage. To the extent the individual's existing health care coverage does not provide coverage for a service furnished prior to the effective date of PACE enrollment, the PACE organization would not receive reimbursement for the provision of that service.

Enrollment denials based on a change in status between the signing of the enrollment agreement and the effective date of enrollment

If the individual experiences a major health event or change in status between the time he/she signs the enrollment agreement and its' effective date on the first of the following month, enrollment may be denied if the individual is no longer determined to be safe to live in the community upon the effective date of enrollment. The effective date of enrollment must be made clear to the enrollee at the time the enrollment agreement is signed. In addition, any services provided prior to the effective date of enrollment are not considered "PACE" services.

PAYMENT

Reimbursement under PACE

Under the Medicare program, the monthly capitation rate paid by CMS to the PACE provider is a blend of two formulas; (1) the county rate book multiplied by a uniform PACE frailty adjuster and (2) a risk adjusted payment methodology. This blend will transition to 100% risk adjustment in the coming years. Under the Medicaid program, the monthly capitation rate is negotiated between the PACE provider and the State Medicaid Agency and is specified in the contract between them. The capitation rate is fixed during the contract year regardless of changes in the participant's health status. The rates are considered payment in full.

RESTRAINTS

Definition of physical restraint in section 460.114(a)(1) of the regulation

The definition of a physical restraint is described in the PACE regulation as any manual method, physical or mechanical device, materials or equipment attached or adjacent to the participant's body that restricts movement. As stated, any material basically becomes a restraint when used to restrict movement and participant access to their body. CMS does not limit its definition to a device or whether the material or equipment is attached to the body. For example, a geri-chair is adjacent to the participant but not attached. A geri-chair restricts movement when the lap table is secured safely in front of a person. In this situation, CMS would consider this a restraint.

What needs to be considered when identifying a physical restraint is if it restricts freedom of movement or access to the body, not the actual method used. For example, a bed sheet tucked into the patient's mattress so that the patient is covered is not a restraint. However, if a sheet were tied around an individual so that it restricts his or her freedom of movement, then CMS would consider this a restraint.

CMS' definition of "physical restraint" in comparison to the definition of the Food and Drug Administration (FDA)

The FDA's definition refers to a device attached to the individual, such as something a patient would wear. The FDA defines a protective restraint as a device that is intended for medical purposes and that limits the patient's movement to the extent necessary for treatment, examination or protection of the patient or others.

STATE READINESS REVIEW

When a Readiness Review is necessary

An organization that is non-operational will have a Readiness Review performed by the State Administering Agency (SAA). This organization will not have any individuals to whom services or care are being provided. This type of organization could be in different phases of "readiness" to operate. However, at the time of the State Readiness Review the organization must have secured a site that will serve as the PACE center, so the SAA can inspect this facility for local, state and federal law compliance. In addition, the organization must have written policies and procedures that are pertinent to operationalize the PACE program, contracts executed in order to provide the comprehensive all-inclusive care that is required in the regulation, and employment agreements for staff described in the regulation.

Survey tool for State use in conducting Readiness Reviews

CMS has provided an internal review tool to the States that outlines the minimum Federal requirements to be included in the State Readiness Review; however, we expect most States will customize this tool to reflect their own individual requirements. The State Readiness Review tool can be located on the PACE Homepage, under the "PACE Information for States and Providers" link.

DATA COLLECTION, RECORD, MAINTENANCE, AND REPORTING

Required use of an Actuarially Certified Statement of Incurred, But Not Reported (IBNR), claims

If a PACE organization is licensed as a Managed Care Organization (MCO) and required by the State Department of Insurance to submit an Actuarially Certified Statement of IBNR claims, this statement should also be submitted to CMS. If a PACE organization or its parent corporation is not licensed as an MCO and is not required by the State to have an Actuarially Certified Statement of IBNR claims completed, this information does not need to be submitted to CMS. A review and evaluation of the IBNR claims should be noted as one of the components of the audit performed to prepare the financial statements.

Required use of the National Association of Insurance Commissioners (NAIC) forms

PACE organizations are not required to use the NAIC forms, known as the "orange blanks," for the submission of financial statements. If a PACE organization already completes these forms because of requirements in its state, the NAIC form would be an acceptable format. Otherwise, financial statements should be prepared on an accrual basis and in accordance with generally accepted accounting principles.

Required audited financial statements of parent organizations

A separate audited financial statement is not required for a PACE organization that is a division or department of a larger corporation. If a PACE organization is a separate entity from the parent corporation, we would like to see the consolidating schedules of the financial statement. The PACE organization is required to submit an annual income statement for PACE operations whether it is a division or separate entity. Quarterly financial statements are required throughout the trial period and at the discretion of CMS or the State Administering Agency thereafter.

OASIS reporting requirements of PACE Organizations licensed as a Home Health Agencies

The PACE organization only needs to comply with OASIS requirements if its state licensed and certified the organization as a Medicare/Medicaid certified HHA. The OASIS requirements relate to certified home health agencies, not PACE organizations that are merely licensed in the state.

DATA ELEMENTS FOR MONITORING

Data Element One - Routine Immunizations

For whom to report information

Data should be reported quarterly for all participants active on the last day of the quarter. Consequently, if a participant disenrolled during a quarter, they would not be included in the data reported.

When to report data

Data on flu shots need only be reported for quarters during which flu shots are administered, i.e., for quarters including the following months: September, October, November, December and January. The Centers for Disease Control (CDC) makes the following recommendation regarding pneumococcal vaccines for persons aged 65 and over: “All persons in this category (65 and over) should receive the pneumococcal vaccine, including previously unvaccinated persons and persons who have not received vaccine within 5 years (and were <65 years of age at the time of vaccination). All persons who have unknown vaccination status should receive one dose of vaccine.” Consequently, some PACE participants may not have had vaccines in the previous 10-year period, but if they had received the vaccine at age 65 or later, they would be appropriately immunized. How should this be handled? For participants who have not received a pneumococcal vaccine in the last 10 years, but are appropriately vaccinated, include them among those not immunized for pneumonia in the last 10 years and indicate they are appropriately vaccinated under reason for not immunizing.

Data Element Two - Grievances And Appeals

Reporting the date of resolution for a grievance or appeal filed in a given quarter but resolved in the following quarter

Report only on grievances and appeals that are resolved in the quarter for which you are reporting. So, "# of grievances filed" should be interpreted as "# of grievances resolved" with the same being true for appeals. This approach allows programs to report the date of resolution for grievances and appeals as indicated on the spreadsheet. For example, if a grievance is filed on March 28 and not resolved by March 31, it should not be included in the "# of grievances filed" for the quarter ending March 31. Alternatively, it should be included in the following quarter's report at which time it can be assigned a resolution date.

Data Element Three - Enrollments

Categorization of enrollees with more than one payer type

A participant should be included in only one of the following categories and the sum of participants in all categories should equal the "# of participants who enrolled." Following are expanded definitions for each payer type:

Medicare only: includes participants with Medicare Part A and Part B coverage, Part A coverage only, or Part B coverage only. These participants do not have Medicaid coverage and pay the long-term care premium privately out-of-pocket.

Medicaid only: includes participants whose only payer is Medicaid.

Dual Eligible: includes participants who are covered by Medicare (A and B, or A only, or B only) AND Medicaid

Private Insurance: includes participants who have long-term care insurance (or other insurance) that pays, either in whole or in part, the long-term care premium

Private Pay: includes participants who pay both the Medicare and Medicaid capitation amounts privately out-of-pocket.

Data Element Four - Disenrollments

Reporting voluntary and involuntary disenrollments

The data requested in this section are only for participants who disenrolled from PACE for a reason other than death. Voluntary disenrollments plus involuntary disenrollments should equal "number of participants disenrolled for reasons other than death". The number of participants who disenrolled due to death is captured elsewhere.

Explanation of "experience with physician" selection for disenrollments

These are participants who disenroll because they have a preference for a non-PACE physician, e.g., their former primary care physician.

Reasons for disenrollment to include in "other"

Disenrollments resulting from any reason other than "leaving the service area," 'experience with physician," or "accessing out of network" should be included in "other." Reasons for "other" disenrollments may include unwillingness to pay the PACE premium, dissatisfaction with some aspect of the program, etc.

Data Element Five - Prospective Enrollees

Definition of "potential participants"

Potential participants are individuals who have initiated the enrollment process and appear to meet the program's basic eligibility requirements, i.e., age 55 or over, live in the program's geographic catchment area and are eligible for nursing home level of care, but DO NOT enroll in PACE.

Clarification of reasons for not enrolling ("physician preference"; how to report individuals with more than one reason; relationship of these reasons to meeting the requirement of being able to live safely in the community)

First, if a person chooses not to enroll due to "physician preference," it means that he/she would prefer to retain their own community physician(s) as opposed to switch to the PACE program's primary care physician or contracted medical specialists. In situations where more than one reason may explain why a participant did not enroll in the program, choose the one you feel describes the reason most accurately and in the greatest detail. Lastly, with the exception of "financial-to avoid cost share," all the specific reasons listed under "doesn't meet eligibility," are intended to provide more detail as to why health and safety are jeopardized by community residence.

Accounting for individuals who initiated the enrollment process in a given quarter, but who have not completed the enrollment process by quarter's end

These individuals, whose status is pending, should not be included in the "# of potential pts interviewed" for that quarter. In a given quarter you should report on potential participants interviewed who have completed the enrollment process and chosen NOT TO ENROLL.

Data Element Six - Hospitalizations

Reporting participants admitted to the hospital more than once

You should report all hospitalizations. So, if a participant is hospitalized twice in a given quarter, report two hospitalizations for that individual. In response to Question 1 under Hospitalizations, be sure to include all hospitalizations including those in which the same participant is readmitted within 31 days for the same diagnosis. In addition, you will report only the number of readmissions within 31 days in response to Question 3 under Hospitalizations.

Reporting diagnoses using ICD-9-CM codes

This is an acceptable method of reporting diagnoses.

Data Element Seven - Emergent Care

Reporting of ER visits

Report total number of ER visits, as opposed to number of participants seen in the ER, to account for participants being seen multiple times in the ER.

Reporting participants seen in the ER and then admitted to the hospital

In this situation, report a hospital admission, not an ER visit.

Data Element Eight - Unusual Incidents

Types of incidents to report

The following is intended to elaborate on the definition of specific incidents:

- All participant falls should be reported, regardless of whether they result in injury. Falls that result in an injury should be reported under falls, as opposed to participant injuries.
- "falls getting into the van" also includes other unusual incidents while on the van, e.g., if something falls or tips over hitting the participant.
- "staff criminal records" refers to criminal activity that occurs after an employee is hired that might impact participants, e.g., theft, assault, drug-related incidents. It does not include traffic violations (unless they involve staff who transport program participants) or other "minor" incidents not impacting participants.
- Referring to "communicable diseases," these include all infectious diseases required to be reported by the Centers for Disease Control.
- "food poisoning" need only be reported if the poisoning can be linked to food provided by a PACE program or contract facility; this would not include poisoning caused by food at a restaurant or from a participant's home.
- "participant injury that required follow-up medical treatment" includes injuries requiring more than first aid, e.g., if a participant tears her skin as a result of hitting her arm on a door and it is addressed with first aid, the incident need not be reported.
- "medication errors" include those in which the wrong drug is administered; the wrong dose is administered; the wrong patient receives a drug; the drug is administered incorrectly via the wrong route; or the drug is administered at the wrong time. In addition, if a patient makes an error self-administering a drug, this should be reported as well.
- "restraints" are defined in the PACE regulation as follows: A physical restraint is any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the participant's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A chemical restraint is a medication used to control behavior or to restrict the participant's freedom of movement and is not a standard treatment for the participant's medical or psychiatric condition.

SANCTIONS

Violations that could trigger CMS to impose sanctions on PACE Organizations

Section § 460.40 specifies that CMS can impose sanctions authorized by law, if CMS determines that a PACE organization has committed any of nine violations. These violations include:

1. The PACE organization fails substantially to provide to a participant medically necessary items and services that are covered PACE services, if failure adversely affected (or has substantial likelihood of adversely affecting) the participant;
2. The PACE organization involuntarily disenrolls a participant in violation of § 460.164;

3. The PACE organization discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid recipients, or both, who are eligible to enroll in PACE program, on the basis of an individual's health status or need for health care services;
4. The PACE organization engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted under §460.150, by Medicare beneficiaries or Medicaid recipients whose medical condition or history indicates a need for substantial future medical services;
5. The PACE organization imposes charges on participants enrolled under Medicare or Medicaid for premiums in excess of the premiums permitted;
6. The PACE organization misrepresents or falsities information that is furnished to HCFA, the State, or to any other individual or entity;
7. The PACE organization prohibits or otherwise restricts a covered health care professional from advising a participant of whether the PACE program provides benefits for that care or treatment, if the professional is acting within his/her scope of practice;
8. The PACE organization operates a physician incentive plan that does not meet the requirements of section 1867 (i)(8) of the Act; and
9. The PACE organization employs or contacts with any individual who is excluded from participating in Medicare or Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization, review, medical social work, or administrative services.

Sanctions CMS may impose upon PACE organizations

Based on the provisions of Section 1857(g)(2), 1857(g)(4) and 1903(m)(5)(B) of the Act, Section 460.42 of the regulation describes two types of sanctions that CMS may impose:

1) Suspension of enrollment of Medicare beneficiaries after the date CMS notifies the organization of the violation. Suspending enrollment of Medicaid recipients is an action taken by the State rather than CMS; and
2) Suspension of payment, CMS may suspend Medicare payment to the PACE organization and deny payment to the State for medical assistance for services furnished under the PACE Program agreement. Section § 460.46 specifies that CMS may also impose civil money penalties.

If CMS, after consulting with the State administering agency, determines that the PACE organization is not in substantial compliance with the PACE regulation, CMS or the State may take one or more of the following actions:

1) condition the PACE program agreement upon a timely execution of a corrective action plan;
2) withhold some or all payments under the PACE program agreement until the deficiency is corrected; or
3) terminate the program agreement.

Do you have an issue we have not addressed? Please E-mail to pace@cms.hhs.gov .

Appendix B

List of PACE Organizations

PACE and Pre-PACE Providers

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so older individuals can continue living in the community. PACE is an innovative model that enables individuals who are 55 years old or older and who are certified by their state to need nursing home care to live as independently as possible. Through PACE, today's fragmented health care financing and delivery system comes together to serve the unique needs of each individual in a way that makes sense to the frail elderly, their informal caregivers, health care providers, and policy makers.

PACE Providers. PACE programs receive Medicare and Medicaid capitation payments for all enrollees eligible for services. Persons financially ineligible for Medicaid must pay that amount privately (out-of-pocket). PACE programs assume full financial risk for enrollees' care without limits on dollars or duration and are responsible for a full range of needed services, including all Medicare and Medicaid benefits.

Pre-PACE Providers. Pre-PACE providers operate under Medicaid contracts. These contracts provide a capitation payment to the Pre-PACE program for long-term care services only. Other Medicare-covered services provided by the Pre-PACE program are billed on a fee-for-service basis. Pre-PACE programs are expected to move into full capitation at a later date.

Alexian Brothers Community Services-Chattanooga
Chattanooga, TN
Phone: (423) 495-9104
Provider Type: PACE

Alexian Brothers Community Services-St. Louis
Saint Louis, MO
Phone: (314) 771-5800, 127
Provider Type: PACE

Allcare
Cedar Bluff, VA
Phone: (276) 964-4915
Provider Type: PACE

AltaMed Senior BuenaCare
Los Angeles, CA
Phone: (323) 278-0411
Provider Type: PACE

Bienvivir Senior Health Services
El Paso, TX
Phone: (915) 562-3444
Provider Type: PACE

Care Resources
Grand Rapids, MI
Phone: (616) 913-2006
Provider Type: PACE

Center for Elders Independence
Oakland, CA
Phone: (510) 433-1150, x8821
Provider Type: PACE

Center for Senior Independence
Detroit, MI
Phone: (313) 653-2222
Provider Type: PACE

Chicago REACH
Chicago, IL
Phone: (773) 252-8989
Provider Type: PRE_PACE

Community Care
Milwaukee, WI
Phone: (414) 902-2401
Provider Type: PACE

Community LIFE
Pittsburgh, PA
Phone: (412) 436-1341
Provider Type: PACE

Comprehensive Care Management
Bronx, NY
Phone: (718) 519-5925
Provider Type: PACE

Concordia Care
Cleveland Heights, OH
Phone: (216) 791-3580
Provider Type: PACE

Eddy SeniorCare
Schenectady, NY
Phone: (518) 382-3290
Provider Type: PACE

Elder Service Plan of Harbor Health Services, Inc.
Dorchester, MA
Phone: (617) 296-5100
Provider Type: PACE

Elder Service Plan of the Cambridge Health Alliance
Cambridge, MA
Phone: (781) 306-8666
Provider Type: PACE

Elder Service Plan of the East Boston Neighborhood Health Center
East Boston, MA
Phone: (617) 568-4873
Provider Type: PACE

Elder Service Plan of the North Shore, Inc.
Lynn, MA
Phone: (781) 715-6608
Provider Type: PACE

Elderhaus, Inc.
Wilmington, NC
Phone: (910) 343-8209
Provider Type: PACE

Florida PACE Centers, Inc.
Miami, FL
Phone: (305) 751-8626
Provider Type: PACE

Hope Select Care
Fort Myers, FL
Phone: (239) 482-4673
Provider Type: PACE

Hopkins ElderPlus
Baltimore, MD
Phone: (410) 550-7124
Provider Type: PACE

Independent Living for Seniors
Rochester, NY
Phone: (585) 922-2836
Provider Type: PACE

LIFE - NWPA
Erie, PA
Phone: (814) 452-3271
Provider Type: PRE_PACE

LIFE - Pittsburgh
Pittsburgh, PA
Phone: (412) 388-8042
Provider Type: PACE

LIFE - University of Pennsylvania School of Nursing
Philadelphia, PA
Phone: (215) 898-4417
Provider Type: PACE

Life at Home
Kennett Square, PA
Phone: (610) 461-3593
Provider Type: PACE

LIFE Geisinger
Kulpmont, PA
Phone: (570) 373-2100
Provider Type: PRE_PACE

Lutheran SeniorLife
Cranberry Township, PA
Phone: (724) 742-2252
Provider Type: PRE_PACE

Mercy LIFE
Philadelphia, PA
Phone: (215) 339-4563
Provider Type: PACE

Midland Care PACE
Topeka, KS
Phone: (785) 232-2044
Provider Type: PACE

Mountain Empire PACE
Big Stone Gap, VA
Phone: (276) 523-4202
Provider Type: PACE

NewCourtland LIFE
Philadelphia, PA
Phone: (267) 335-1501
Provider Type: PRE_PACE

On Lok Lifeways
San Francisco, CA
Phone: (415) 292-8882
Provider Type: PACE

PACE CNY
North Syracuse, NY
Phone: (315) 413-4527
Provider Type: PACE

PACE Greater New Orleans
New Orleans, LA
Phone: (504) 941-6042
Provider Type: PACE

PACE Organization of Rhode Island
Providence, RI
Phone: (401) 490-6566
Provider Type: PACE

PACE Vermont, Inc.
Colchester, VT
Phone: (802) 655-6700, x101
Provider Type: PACE

Palmetto SeniorCare
Columbia, SC
Phone: (803) 434-3770
Provider Type: PACE

Providence ElderPlace - Seattle
Seattle, WA
Phone: (206) 320-5325
Provider Type: PACE

Providence ElderPlace in Portland
Portland, OR
Phone: (503) 215-3612
Provider Type: PACE

Riverside PACE
Newport News, VA
Phone: (757) 251-7977
Provider Type: PACE

Senior Health Partners, Inc.
New York, NY
Phone: (212) 870-4610
Provider Type: PRE_PACE

SeniorLIFE Johnstown
Johnstown, PA
Phone: (814) 535-6000
Provider Type: PACE

Sentara Life Care Corporation
Norfolk, VA
Phone: (757) 892-5400, x5403
Provider Type: PACE

St. Paul's PACE
San Diego, CA
Phone: (619) 677-3800
Provider Type: PACE

Summit ElderCare
Worcester, MA
Phone: (508) 368-9437
Provider Type: PACE

Sutter SeniorCare
Sacramento, CA
Phone: (916) 424-8412
Provider Type: PACE

The Basics at Jan Werner
Amarillo, TX
Phone: (806) 374-5516
Provider Type: PACE

Total Aging in Place
Amherst, NY
Phone: (716) 250-3108
Provider Type: PRE_PACE

Total Community Care, LLC
Albuquerque, NM
Phone: (505) 924-2606
Provider Type: PACE

Total Longterm Care
Denver, CO
Phone: (720) 974-6754
Provider Type: PACE

TriHealth SeniorLink
Cincinnati, OH
Phone: (513) 458-8801
Provider Type: PACE

Upham's Elder Service Plan
Boston, MA
Phone: (617) 288-0970
Provider Type: PACE

Via Christi HOPE
Wichita, KS
Phone: (316) 946-5202
Provider Type: PACE

Appendix C

National PACE Association
Summary of the Final Part D Regulation

National PACE Association

Responding to the Unique Needs of Seniors and their Families

Medicare Part D Prescription Drug Benefit

Summary of Final Part D Regulation, 42 CFR Part 423, for PACE Organizations

(Final Part D Regulation available on NPA web site: http://www.NPAonline.org/website/download.asp?id972)

Section	Summary
Subpart A - General Provisions (pp. 4527-4528; preamble pp. 4199-4201)	
Sec. 423.1 - Basis and scope	42 CFR Part 423 establishes standards for beneficiary eligibility, access, benefits, protections, and low-income subsidies in Part D; and establishes standards and sets forth requirements, limitations, procedures and payments for organizations participating in the Medicare Prescription Drug Program.
Sec. 423.4 - Definitions	Defines terms relevant to the Medicare Prescription Drug Program including: PACE plan which is defined as a Part D plan offered by a PACE organization; and Service area which, when applied to a PACE plan, is defined as the service area identified in the PACE Program Agreement and referred to in §460.22.
Sec. 423.6 - Cost-Sharing in beneficiary education and enrollment-related costs	Applies cost-sharing requirements for enrollment related costs to Prescription Drug Plan (PDP) sponsors under Part D. This is analogous to cost-sharing requirements imposed on MA-PDs for enrollment related costs, e.g. CMS beneficiary education activities. *NOTE: CMS waived requirements related to PACE organizations' submission of information for beneficiary education under §423.48, but did not respond to NPA's request to waive cost-sharing under 423.6. NPA to follow-up with CMS on this issue.*
Subpart B - Eligibility and Enrollment (pp. 4528-4533; preamble pp. 4201-4228)	
Sec. 423.30 - Eligibility and enrollment	Establishes individual eligibility requirements for Part D. All dual eligible and Medicare-only PACE enrollees are eligible for Part D. Medicaid-only enrollees are not eligible for Part D benefits. Further, under §423.30(c), a Part D eligible individual enrolled in a PACE plan must obtain Part D coverage through his/her PACE organization.
Sec. 423.32 - Enrollment process	Per §423.32(f) individuals enrolled in a PACE organization as of December 31, 2005 will remain enrolled in that PACE organization as of January 1, 2006, and receive Part D benefits through that PACE organization. Subsequently, he/she will remain enrolled in the PACE organization until: 1) he/she enrolls in a PDP or Medicare Advantage Prescription Drug Plan (MA-PD); 2) he/she voluntarily disenrolls from the PACE organization; 3) he/she is involuntarily disenrolled from the PACE organization; or 4) the PACE organization is discontinued in the enrollee's service area.
Sec. 423.34 - Enrollment of full-benefit dual eligibles	Because payment for Part D covered drugs will no longer be made by Medicaid, dual eligibles must enroll in a PDP, MA-PD or PACE organization by January 1, 2006 in order to have coverage of Part D covered drugs. This section speaks to the process CMS will use to enroll dual eligibles in a PDP or, for those individuals enrolled in a Medicare Advantage plan, an MA-PD plan. In particular, the section describes the process by which dual eligibles will be automatically enrolled in a PDP

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	in the event they do not elect a Part D plan, are not deemed enrolled in a MA-PD plan, or are not enrolled in a PACE organization's Part D plan as described above under §423.32(f).
Sec. 423.36 - Disenrollment process	Disenrollment requirements currently in place for PACE under §§460.162-166 will not be impacted by Part D. A Special Election Period (SEP) will be created such that a beneficiary may disenroll from PACE into a PDP at any point during the year and vice versa. Such a SEP is currently in place to allow beneficiaries to move between PACE and Medicare Advantage plans throughout the year.
Sec. 423.38 - Enrollment periods	Enrollment requirements currently in place for PACE under §§460.152-460.160 will not be impacted by Part D. In general, beneficiaries enrolling in PACE, as a consequence of that enrollment, agree to receive their Part D coverage through PACE. As described above, a SEP will allow qualified beneficiaries to disenroll from their PDP or MA-PD plan throughout the year in order to enroll in PACE.
Sec. 423.40 - Effective dates	Effective dates of enrollment in PACE will not be impacted by Part D. Under §460.158, enrollment is effective on the first day of the calendar month following the date that a PACE organization receives the signed enrollment agreement.
Sec. 423.44 - Involuntary disenrollment by PDP ***WAIVED FOR PACE***	Involuntary disenrollment requirements currently in place for PACE under §460.164 will not be impacted by Part D. Part D requirements under §423.44 related to involuntary disenrollment have been waived for PACE.
Sec. 423.46 - Late enrollment penalty	Under Part D, if a beneficiary delays enrollment in Part D and does not have "creditable drug coverage" (as described in §423.56) in place during that period, he/she incurs a penalty such that subsequent Part D premiums are increased. In the absence of creditable drug coverage, a penalty will be applied to both Medicare-only and dual-eligible beneficiaries such that their future Part D premiums are increased. This provision will impact the Part D premiums paid by Medicare-only beneficiaries enrolled in PACE in the event that, prior to their enrollment in PACE, they had lapses in creditable coverage. Late enrollment penalties will not impact dual eligibles enrolled in PACE because PACE organizations are prohibited from charging premiums to dual eligible enrollees. CMS will cover most, if not all, late enrollment penalties for dual eligibles per §423.780(e).
Sec. 423.48 - Information about Part D ***WAIVED FOR PACE***	CMS will require Part D plans to provide, on an annual basis, information to CMS that will be used to provide beneficiaries with information they need to choose among the Part D plans available to them. CMS has waived this requirement for PACE in order to better coordinate benefits between Part D and PACE.
Sec. 432.50 - Approval of marketing materials and enrollment forms ***WAIVED FOR PACE***	In general, the requirements related to approval of marketing materials and enrollment forms under Part D are similar to marketing requirements already in place for PACE organizations under §460.82. To the extent there is inconsistency, CMS has waived Part D marketing requirements for PACE.
Sec. 423.56 - Procedures to determine and document creditable status of prescription drug coverage	As discussed above in the context of the late enrollment penalty, the Part D rule addresses the issue of creditable drug coverage. Drug coverage provided by PACE organizations is defined as creditable drug coverage for purposes of Part D. Although certain disclosure requirements related to creditable drug coverage apply to various types of entities, e.g., State Pharmaceutical Assistance Programs, Medigap insurers, they do not apply to PACE organizations.

Section

Subpart C - Benefits and Beneficiary Protections (pp. 4533-4540; preamble pp. 4228-4276)

Sec. 423.100 - Definitions

Summary

Numerous terms are defined in this section. Most importantly:

- Various types of drug coverage are defined using Part D terminology. These include basic and alternative prescription drug coverage and, within alternative prescription drug coverage, basic alternative coverage and enhanced alternative coverage. Under §460.90 and §460.92(m), PACE organizations are required to provide all medically necessary drugs and biologicals without limits or conditions related to amount or duration. In Part D terms, PACE organizations will provide enhanced alternative coverage which includes basic Part D prescription drug coverage and supplemental benefits.
- Dispensing fees are defined as costs that are (1) incurred at the point of sale and pay for costs in excess of the ingredient cost of a covered Part D drug each time a covered Part D drug is dispensed; (2) include only pharmacy costs associated with ensuring that possession of the appropriate covered Part D drug is transferred to a Part D enrollee. Pharmacy costs include, but are not limited to, any reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing quality assurance activities, measurement or mixing of the covered Part D drug, filling the container, physically providing the completed prescription to the Part D enrollee, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy. In the case of pharmacies owned and operated by a Part D plan, dispensing fees include the salaries of pharmacists and other pharmacy workers. Dispensing fees do NOT include administrative costs incurred by the Part D plan in the operation of the Part D benefit, including systems costs for interfacing with pharmacies.
- Part D drug is defined in detail on p. 4534. In brief, Part D drugs include prescription drugs that are not covered under Medicare Parts A or B or specifically excluded under Part D. Non-Part D drugs, or drugs specifically excluded from Part D coverage, are: barbiturates; benzodiazepines; over-the-counter drugs; agents when used for anorexia, weight loss or gain; agents when used for cosmetic purposes or hair growth; agents when used for symptomatic relief of cough and colds; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.

Note: The final instructions related to Prescription Drug Event data reporting requirements elaborate further on Part D and Non-Part D drugs (www.cms.hhs.gov/pdps/FINALPAPER041205.pdf) on pp. 18-19 as does Guidance on Medicare Part B versus Part D Coverage Issues (www.cms.hhs.gov/pdps/PartB_DdocRevised3-30-05.pdf). It is critical to distinguish between Part D drugs and Non-Part D drugs and, within Part D drugs, Covered and Non-covered Part D drugs. Covered Part D drugs meet the definition of a Part D drug and are also on the plan's formulary, or are not on the formulary but a non-coverage determination was successfully appealed. Non-covered Part D drugs are drugs that meet the definition of a Part D drug but are not covered by the plan, usually because it is off formulary or the plan does not find it reasonable and necessary. Distinctions between Part D and Non-Part D drugs, and Covered and Non-covered Part D drugs are important for many reasons including (1) calculating Part D bids so as not to include the cost of Non-Part D drugs and Non-covered Part D drugs in the standard Part D bid; and (2) State UPL/rate negotiations because Medicaid payment for Non-Part D drugs for all Medicaid enrollees, including dual eligibles, can continue to the extent the State opts to cover such drugs. States are prohib-

Section	Summary
	ited from paying for Part D drugs, regardless of whether they are covered or non-covered by a particular plan.
Sec. 423.104 - Requirements related to qualified prescription drug coverage *§423.104(g)* ***WAIVED FOR PACE***	Describes the overall structure of the Part D prescription drug benefit including the standard Part D benefit which includes: ■ $250 deductible; ■ 25% beneficiary coinsurance for drug costs between $250 and $2,250; ■ 100% beneficiary coinsurance for drug costs between $2,250 and $5,100; and ■ 5% beneficiary coinsurance for drug costs exceeding $5,100. *Note: Specific dollar amounts noted above are for 2006.* PDPs and MA-PDs may offer "alternative prescription drug coverage" that alters the configuration of the benefit according to a defined set of regulatory requirements, e.g., by altering cost-sharing levels. They may also offer "enhanced alternative coverage" that includes supplemental benefits beyond standard or alternative Part D coverage. Under §460.90 and §460.92, PACE organizations are required to provide comprehensive coverage of all medications; so, in Part D terms, they will provide enhanced alternative coverage. §423.104(g) establishes requirement for Part D plans to provide enrollees access to their plan's negotiated prices for covered part D drugs included in their formularies. This requirement has been waived for PACE.
Sec. 423.112 - Establishment of prescription drug plan service areas ***WAIVED FOR PACE***	PACE organizations' service areas are defined in §460.22 and not altered by Part D; requirements under §423.122 have been waived for PACE.
Sec. 423.120(a) - Access to covered Part D drugs - Assuring pharmacy access ***WAIVED FOR PACE***	Recognizing differences in how PACE organizations meet their enrollees' drug needs, CMS has waived certain Part D requirements under §423.120 including §423.120(a). PACE organizations will not be required to modify their pharmacy networks as a consequence of Part D pharmacy access requirements.
Sec. 423.120(b) - Access to covered Part D drugs - Formulary requirements (pp. 4537- 4538; preamble pp. 4255- 4267)	Establishes requirements for Part D plans, including PACE organizations, that use formularies, including: ■ Formulary must be developed and reviewed on an ongoing basis by a Pharmacy and Therapeutic (P&T) Committee that: -- includes a majority of practicing physicians and/or practicing pharmacists; -- includes at least one practicing physician and at least one practicing pharmacist who are independent and free of conflict relative to the Part D sponsor and Part D plan, and pharmaceutical manufacturers (Note: P&T Committee members must sign a conflict of interest statement revealing all economic relationships that could influence their decision-making); -- includes at least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals; -- bases clinical decisions on scientific evidence and standards of practice; -- considers whether inclusion of a particular drug has therapeutic advantages in terms of safety and efficacy;

-- meets at least quarterly;
-- reviews policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, generic substitution, and therapeutic interchange;
-- evaluates and analyses treatment protocols and procedures related to the plan's formulary at least annually;
-- documents its decisions in writing regarding formulary development and revision, and utilization management activities.

■ Generally, Part D plans' formularies must provide for an adequate benefit as determined by (1) the inclusion of at least two Part D drugs that are not therapeutically equivalent in each therapeutic category and class of part D drugs, with different strengths and dosage forms, whenever possible; and (2) adequate coverage of the types of drugs most commonly needed by Part D enrollees.
For more information on Part D formulary issues, go to http://www.cms.hhs.gov/pdps/FrmUpldInstGdncMatrl.asp, where CMS has posted the following:

- Formulary Upload Technical User Instructions and Appendices
- CMS Strategy for Affordable Access to Drugs Covered Under MMA - description of framework for CMS' review of Medicare Part D plans' formularies
- Guidance on Medicare Part B Versus Part D Coverage Issues
- Comprehensive Listing of Drugs in the USP Model Guidelines.

■ Part D plans must provide for an appropriate transition process for new enrollees prescribed Part D drugs that are not on its formulary (see Transition Process Guidance at www.cms.hhs.gov/pdps/transition_process.pdf) .

■ Part D contractors (claims management companies, PBMs, etc.) must meet all applicable requirements regarding formulary development and application.

■ Generally, Part D plans may not change the therapeutic categories and classes in their formularies other than at the beginning of each plan year.

■ Part D plans must provide at least 60 days notice to affected enrollees, prescribers, pharmacies, CMS, etc. regarding certain formulary changes, e.g., removal of a drug.

On pp. 10-11 of the PACE Part D application (www.cms.hhs.gov/pace/part_d_app.pdf), CMS identifies five criteria that PACE organizations can use to determine whether or not they utilize a formulary. If their policies include any one of the following, a formulary is in place and must be submitted to CMS for approval:

1. Cost-sharing tiers - This won't apply to PACE organizations because they are prohibited from charging co-payments.
2. Prior authorization - Any coverage list that contains one or more drugs that must undergo prior authorization before dispensing is considered a formulary. If in the normal course of clinical practice, the prescribing physician uses FDA-approved indications and use criteria to determine appropriateness of therapy, this is not considered prior authorization.
3. Step therapy - Any coverage list that contains one or more drugs that are part of a step therapy management program is considered a formulary. This includes any program that requires a certain drug to be used first, before a different drug

Section	Summary
	can be dispensed. Step therapy can apply to certain drug classes or among brand and generic drug combinations. 4. Quantity limitations - Any coverage list that contains one or more drugs with quantity limits is considered a formulary. Common examples include erectile dysfunction drugs and antimigraine drugs. 5. Steerage - Any coverage list that contains one or more drugs that are considered preferred or drugs that are steered towards is considered a formulary. Common prescribing patterns are not considered steerage as long as there are no adverse consequences to physicians or patients if a particular drug is not chosen.
Sec. 423.120(c) - Access to covered Part D drugs - Use of standardized technology ***WAIVED FOR PACE***	CMS has waived this requirement - which requires Part D sponsors to issue a card or other type of technology that its enrollees may use to access negotiated prices for covered Part D drugs - for PACE.
Sec. 423.124 - Special rules for out-of-network access to covered Part D drugs at out-of-net work pharmacies ***WAIVED FOR PACE***	CMS has waived this requirement related to insuring beneficiaries access to drugs at out-of-network pharmacies for PACE because it is duplicative of requirements under §460.100 and in conflict with §460.90(a).
Sec. 423.128 - Dissemination of Part D plan information ***WAIVED FOR PACE***	CMS has waived this requirement related to dissemination of Part D plan information for PACE because it is duplicative of requirements under §460.112(b). The types of information identified in §423.128 include: description of Part D plan and its content; service area; benefits; formulary; access; out-of-network coverage; grievance and appeals procedures; quality assurance policies and procedures; disnerollment rights and responsibilities; etc.
Sec. 423.132 - Public disclosure of pharmaceutical prices for equivalent drugs ***WAIVED FOR PACE***	CMS has waived this requirement for PACE to promote coordination of benefits between Part D and PACE.
Sec. 423.136 - Privacy, confidentiality and accuracy of enrollee records ***WAIVED FOR PACE***	CMS has waived these requirements for PACE because they are duplicative of requirements under §460.200(d) and §460.200(e).
Subpart D - Cost Control and Quality Improvement (pp. 4540- 4544; preamble pp. 4276- 4288)	
Sec. 423.150 - Scope	This section of the rule sets forth requirements related to the following: drug utilization management programs; quality assurance measures and systems; medication therapy management programs (MTMPs); consumer satisfaction surveys; electronic prescription program; quality improvement organization (QIO) activities; compliance deemed on the basis of accreditation; accreditation organizations; and procedures for approval of accreditation organizations as a basis for deeming compliance.

Section	Summary
Sec. 423.153 - Drug utilization management, quality assurance and medication therapy management programs (MTMPs) ***WAIVED FOR PACE***	For purposes of this requirement: ■ Drug utilization management program includes incentives to reduce costs when medically appropriate; policies and systems to assist in preventing over-utilization and under-utilization of prescribed medications; and mechanisms to provide CMS with information concerning the procedures and performance of its drug utilization management program. ■ Quality assurance measures and systems are required to reduce medication errors and adverse drug interactions and improve medication use and include (1) evidence that network providers are compliant with State minimum standards for pharmacy practice, (2) concurrent drug utilization review systems, policies and procedures; (3) retrospective drug utilization review systems, policies and procedures; (4) internal medication error identification and reduction systems; (5) provision of information to CMS regarding QA measures and systems. ■ MTMP program designed to ensure that covered Part D drugs prescribed to targeted beneficiaries, e.g. beneficiaries with chronic diseases or taking multiple drugs, are appropriately used to optimize therapeutic outcomes through improved medication use. CMS has waived requirements under §423.453 as duplicative of PACE requirements under §460.102(d), §460.106 and §460.134. *NOTE: Costs associated with implementing drug utilization management, quality assurance and MTMPs are all allowable administrative costs for purposes of the Part D bid; in order to develop an accurate bid, PACE organizations must project the costs associated with these activities and include them in their bids.*
Sec. 423.156 - Consumer satisfaction surveys ***WAIVED FOR PACE***	In this section of the regulation and corresponding preamble, CMS refers to the consumer satisfaction surveys it administers to Medicare Advantage enrollees - the Consumer Assessment of Health Plans (CAHPs). Currently, the CAHPs survey is not administered to PACE enrollees; rather, PACE enrollees participate in consumer satisfaction surveys administered by PACE organizations under §460.134. CMS has waived this requirement for PACE as duplicative of §460.134(a)(2).
Sec. 423.159 - Electronic prescription program	Part D sponsors must support and comply with electronic prescription standards relating to covered Part D drugs for Part D enrollees developed by CMS once final standards are effective. On February 4, 2005, proposed rules for the Electronic prescription program were published in the Federal Register (http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1773.pdf). Final standards for electronic prescribing must be published not later than 4/1/08 and take effect not more than one year after that.
Sec. 423.162 - Quality improvement organization (QIO) activities ***WAIVED FOR PACE***	The MMA expanded the role of QIOs to include Part C (Medicare Advantage) and Part D. QIOs are required to offer providers, practitioners, and Part D sponsors quality improvement assistance pertaining to health care services, including those related to prescription drug therapy. CMS has waived this requirement for PACE as duplicative of requirements in Subpart H of 42 CFR Part 460 and to promote coordination of benefits between PACE and Part D.
Sec. 423.165 - Compliance deemed on the basis of accreditation	Explains process by which compliance of Part D sponsors with certain Part D requirements can be deemed by accreditation organizations. *NOTE: Presently, PACE organizations are not deemed compliant with any PACE requirements as a consequence of accreditation.*

Section	Summary
Sec. 423.168 - Accreditation organizations	Establishes requirements for accreditation organizations.
Sec. 423.171 - Procedures for approval of accreditation as a basis for deeming compliance	Describes process by which CMS will approve accreditation organizations.
Subpart E - Reserved	
Subpart F - Submission of Bids and Monthly Beneficiary Premiums; Plan Approval (pp. 4544-4546; preamble pp. 4288-4306)	
Sec. 423.251 - Scope	This subpart sets forth the requirements and limitations on submission, review, negotiation and approval of competitive bids for PDPs , MA-PD plans and PACE organizations; the calculation of the national average monthly bid amount and the determination of enrollee premiums.
Sec. 423.258 - Definitions	Relevant to PACE, the standardized bid amount is defined as the portion of the PACE plan's approved bid that is attributable to basic prescription drug coverage.
Sec. 423.265 - Submission of bids and related information *BID SUBMISSION DEADLINE UNDER §423.265(b)* ***WAIVED FOR PACE***	All Part D plans, including PACE organizations, must submit bids and supplemental information in a format specified by CMS. Per CMS' 45-Day Notice of Payment (http://www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf , pp. 58-60) PACE organizations will need to have two separate benefit plans and two separate Part D bids, one for dual eligibles enrolled in a standard benefit plan, the other for the Medicare-only population enrolled in an enhanced alternative plan. Each bid must reflect a uniform benefit package, including premium and all applicable cost-sharing. Each bid must reflect the PACE organization's estimate of its average monthly revenue requirements to provide prescription drug coverage, including supplemental coverage, for a Part D eligible individual with a "national average risk profile." *NOTE: Although PACE organizations do not enroll individuals with an average risk profile, PACE prescription drug utilization and cost experience can be used, at least in part, as the basis for Part D bids. For PACE organizations with no or insufficient census from which to develop a creditable bid, additional data will have to be used.* The bid submission must include all costs associated with provision of basic and supplemental benefits, including the cost of medications, dispensing and administrative costs. The bid does not include costs associated with payments made by the enrollee (or CMS on behalf of an enrollee eligible for low-income subsidies) for the annual deductible and co-payments, payments projected to be made by CMS for reinsurance, or any other costs for which the Part D sponsor is not responsible. The bid must be prepared in accordance with CMS actuarial guidelines and be certified by a qualified actuary who is a member of the American Academy of Actuaries. The bid and supplemental information submission must include the following information: (1) description of the coverage to be provided, including any supplemental coverage; (2) actuarial value of the coverage to be offered for an individual with a national average risk profile, distinguishing between the portions of the bid attributable to basic Part D coverage and supplemental coverage; (3) assumptions underlying reinsurance amounts used in calculating the bid; (4) assumptions regarding low-income cost-sharing used in calculating the bid; (5) administrative

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	costs and return on investment included in the bid; (6) a description of the plan's service area; and (7) an estimate of the plan's average prescription drug risk score. CMS has posted the Draft PDP Bid Instructions and Pricing Tool on its website at www.cms.hhs.gov/pdps/BidInst.asp . This information will be updated, but it is important that all PACE organizations and prospective PACE organizations that anticipate submitting Part D bids in 2005 understand Part D bid requirements. In general, the bid submission deadline for Part D plans is the 1st Monday in June; in 2005 this is 6/6/2005. However, in the event a PACE organization cannot meet the 6/6/2005 deadline, it can apply for a waiver of the bid submission deadline by reviewing the guidance and completing the bid submission deadline waiver request form located at www.cms.hhs.gov/pace/part_d_waiverguidance.pdf and www.cms.hhs.gov/pace/part_d_waiverform.pdf, respectively. For 2005, bid submission deadlines can be extended until July 1, 2005; deadline waiver request forms must be submitted no later than May 6th, 2005. The bid submission deadline is automatically waived for prospective PACE organizations in that their timeframe for bid submissions will not correspond with the annual PDP/MA-PD application/bid process. Lastly, for purposes of 2006 bid development, most PACE organizations are participating in a collective Part D bid project initiated by NPA. For more information on the project, contact Chris van Reenen at NPA at chrisvr@npaonline.org.
Sec. 423.272 - Review and negotiation of bid and approval of plans submitted by potential Part D sponsors	Specifies that CMS will review bid submissions and has authority under the MMA to negotiate regarding the terms and conditions of the proposed bid and benefit plan. CMS will approve plans only if they comply with all applicable Part D requirements, including: ■ Part D bids must be actuarially certified, and reasonably and equitably reflect the revenue requirements for the benefits provided under the plan, less the sum of the actuarial value of reinsurance payments. ■ The design of the plan cannot substantially discourage enrollment by certain Part D eligible individuals (this will be evaluated in part by review of the plan's formulary, if any).
Sec. 423.279 - National average monthly bid amount	Each year CMS will calculate a national average monthly bid amount. Note: Bids submitted by PACE plans will not be used in calculating the nat'l avg. monthly bid amount. How the nat'l avg. monthly bid amount is used in calculating CMS payments and private-pay premiums for Part D is explained below under Subpart G.
Sec. 423.286 - Rules regarding premiums	In general, the monthly beneficiary premium for a Part D plan is equal to the Base Beneficiary Premium PLUS the difference between the plan bid and the nat'l avg. monthly bid amount PLUS the portion of the plan bid attributable to supplemental benefits. For an example of how the beneficiary premium is calculated and its relationship to the nat'l avg. monthly bid amount, refer to Example 1 in the NPA memo dated 11/10/2004 (Medicare Part D Summary Memo) located at www.npaonline.org/website/article.asp?id=769.
Sec. 423.293 - Collection of monthly beneficiary premium	PACE Part D plans will charge Medicare-only enrollees a consolidated monthly Part D premium equal to the sum of the Part D monthly premium for basic Rx drug coverage and the premium for supplemental coverage. Referring to the preamble discussion, enrollees have the option of having premium amounts withheld from their Social Security checks,

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	or making premium payments directly to the Part D plan through an electronic funds transfer mechanism. If premium amounts are withheld from enrollees' Social Security checks, CMS will then pay the Part D plan.
Subpart G - Payments to Part D Plan Sponsors For Qualified Prescription Drug Coverage (pp. 4546-4551; preamble pp. 4306-4317)	Under Part D, Medicare becomes the primary payer for coverage of Part D covered drugs. As a result, Medicaid capitation rates paid to PACE organizations will decrease. In order to determine the amount of the reduction in Medicaid capitation rates, States must recalculate Upper Payment Limits (UPLs) for PACE exclusive of costs for Part D covered drugs. If Medicaid capitation rates for PACE are set at a percentage of the UPL, rates will decrease accordingly. Medicaid capitation rates determined by other methods, e.g. premium proposals, will also need to be adjusted to reflect that Medicaid is no longer the primary payer for Part D covered drugs. In addition, as a consequence of Part D, CMS believes that States will need to establish separate capitation rates for Medicaid eligible PACE enrollees, including one for dual eligible beneficiaries covered under Part D and one for Medicaid-only beneficiaries for whom Medicaid will remain the payer for Part D covered drugs (refer to p. 4433 of the preamble to the Part D rule for discussion of this topic). In anticipation of Part D implementation, PACE (and pre-PACE) organizations should begin discussions with their States on this issue. In general, CMS payments to Part D plans will consist of monthly payments; reinsurance subsidies; risk-corridor payment adjustments; and, for eligible enrollees, low-income subsidy payments. In addition, for dual eligible enrollees, CMS will make payments to PACE organizations covering dual eligibles' co-payment amounts and, if necessary, beneficiary premium amounts (pp. 58-59 of http://www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf). For a general discussion of Part D payment in non-regulatory language, refer to NPA's Medicare Part D Summary Memo at www.npaonline.org/website/article.asp?id=769.
Sec. 423.301 - Scope	This subpart sets forth rules for calculation and payment of CMS direct and reinsurance subsidies; the application of risk corridors and risk-sharing adjustments to payments; and retroactive adjustments and reconciliations to actual enrollment and interim payments.
Sec. 423.308 - Definitions and terminology	Key terms are defined.
Sec. 423.315 - General payment provisions	Monthly payments: Equal to the Part D plan's standardized bid, risk adjusted for health status, minus the monthly beneficiary premium. Reinsurance subsidies: Payments made on behalf of enrollees with annual prescription drugs costs in excess of the annual out-of-pocket threshold. Low-income subsidies: premium and cost-sharing subsidies made on behalf of subsidy-eligible enrollees. Risk-corridor payments: Payments made in the event that the plan's overall cost experience is substantially higher than anticipated. Note: If the plan's cost experience is substantially lower than anticipated, the plan must pay back a portion of its surpluses to CMS. This section also speaks to retroactive adjustments and reconciliations that apply under Part D.
Sec. 423.322 - Requirement for disclosure of information	Payments to Part D sponsors are conditioned upon provision of information to CMS.

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Sec. 423.329 - Determination of payments

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This section describes in more detail the types of payments that will be made under Part D including: monthly subsidy payments, reinsurance subsidies, and low-income cost-sharing subsidies.

CMS will make monthly subsidy payments for each Part D enrollee equal to the amount of the plan's approved standardized bid, adjusted for health status, and reduced by the beneficiary premium. This section also speaks to the risk adjustment methodology that CMS will use in adjusting bids for individual enrollees' health status. In a manner similar to risk-adjustment under Parts A and B, CMS will calculate a risk score for each individual enrolled in Part D. The Part D risk score is then applied to the Part D plan's standardized bid. CMS describes in detail the Part D risk adjustment model in its 45-Day Notice of Payment (pp. 38-61, http://www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf)

This section also speaks to CMS' authority to require Part D plans to submit data on drug claims. In general, the data collection and submission requirements related to Part D are substantial and will include the collection/submission of specified data elements related to each prescription filled on behalf of a PACE enrollee. In general, the data reporting requirements are generally based on the expectation that PDPs and MA-PDs contract with Pharmacy Benefit Managers (PBMs) to administer the Part D benefit and that the data required by CMS will be generated as a consequence of the electronic exchange between pharmacies, PBMs and PDPs in adjudicating prescription drug claims. Relationships between PACE organizations and PBMs are not the norm, however. In many cases, PACE organizations contract directly with retail pharmacies or operate in-house pharmacies. Regardless, PACE organizations will have to develop processes for complying with Part D data requirements. In some cases, this may prompt PACE organizations to consider, if not ultimately pursue, a relationship with a PBM. NPA encourages PACE organizations to review the data requirements carefully as soon as possible in that they have consequences in the immediate short-term for bid development, i.e., costs related to complying with the data requirements must be incorporated into Part D bids.

More detail regarding Prescription Drug Event (PDE) data reporting requirements, including a list of specific data elements, is available in a CMS document titled Instructions: Requirements for Submitting Prescription Drug Event Data at www.cms.hhs.gov/pdps/FINALPAPER041205.pdf. This document should be read in conjunction with guidance specific to PACE organizations that identifies modifications to the standard PDE requirements for PACE. The PACE-specific guidance is titled Instructions for Submitting Prescription Drug Event Data: Rules for PACE Organizations and can be found at www.cms.hhs.gov/pdps/FinalPACE051005.pdf. For example, PACE organizations will not be required to report data elements including: patient pay amount, low income cost sharing subsidy amount and other TrOOP amount as well as items related to the attachment point.

Reinsurance payment amounts are defined as 80% of the allowable reinsurance costs attributable to that portion of gross covered prescription drugs costs incurred in the coverage year after the individual has incurred true out-of-pocket costs that exceed the annual out-of-pocket threshold ($3,600 in 2006). PACE organizations are eligible to receive reinsurance payments for their dual eligible enrollees and other enrollees who qualify for low-income cost-sharing subsidies. In Part D terms, this is because cost-sharing subsidies count toward these enrollees' true out-of-pocket costs, also known as TrOOP (True Out-of-Pocket). This is not the case for Medicare-only enrollees, however, who do not accumulate TrOOP because they do not incur deductibles and co-payments under PACE.

Low-income cost sharing subsides will include: premium subsidies, and deductible and cost-sharing subsidies. In essence, for dual eligibles, CMS will pay a premium subsidy in place of the beneficiary premium described in §423.293. CMS will also subsidize dual eligibles'

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	deductible and cost sharing amounts at all levels, i.e., the 25% cost-share for drug costs between $250 and $2,250, the 100% cost-share for costs between $2,251 and $5,100, and the 5% cost-share for costs above $5,100. While, in general, dual eligibles will have nominal co-payments under Part D up to the out-of-pocket threshold, this is not possible for PACE enrollees who cannot be charged copayments under §460.90(a). For PACE, CMS will pay these co-payment amounts as described in the 45-Day Notice of Payment (pp. 58-59, www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf).
Sec. 423.336 - Risk-sharing arrangements	This section describes in detail the risk-sharing arrangement that exists within the Part D program. Rather than trying to summarize the details here, please refer to pp. 4548-4549 of the final rule and the corresponding preamble discussion on pp. 4314-4315. While this is an important piece of the overall Part D payment approach, it does not have immediate consequences for calculating Part D bids amounts, or answer more immediate questions regarding whether or not to utilize a formulary or how best to meet Part D data requirements.
Sec. 423.343 - Retroactive adjustments and reconciliations	Describes circumstances under which retroactive payment adjustments and reconciliations may be required. Such adjustments may be related to the Part D risk adjustment methodology consistent with the adjustments and reconciliations that PACE organizations currently experience under risk adjustment for payment for Part A and B covered services. Referring to reinsurance subsidies for enrollees whose out-of-pocket costs exceed the $3,600 threshold, CMS plans to make monthly prospective payments of estimated allowable reinsurance costs based on assumptions related to reinsurance included in each plan's bid. At the end of the calendar year, CMS will reconcile plans' allowable incurred reinsurance costs with the prospective plan payments that were made throughout the year. Plans will then be reimbursed for any underestimation of costs or CMS will recover overpayments. Payment or recovery may be made on a lump sum basis or by adjusting payments throughout the remainder of the payment year following the coverage year for which retroactive adjustments are being made. CMS plans to issue further guidance on this topic. As is the case with reinsurance payments, CMS plans to make low-income cost sharing subsidy payments on a prospective basis using estimates submitted with plans' bids. These payments will then be reconciled after the end of the coverage year based on actual claims data.
Sec. 423.346 - Reopening	Describes process for reopening and revising an initial or reconsidered final payment determination.
Sec. 423.350 - Payment appeals	Defines situations in which payment determinations may and may not be appealed; and the processes related to payment appeals.
Subpart H - Reserved	
Subpart I - Organization Compliance with State Law and Preemption by Federal Law (pp. 4551-4552; preamble pp. 4317-4320)	CMS has waived requirements of Subpart I recognizing that PACE organizations' fiscal soundness is governed under sections 1894(e)(2)(iv) and 1934(e)(iv) of the Social Security Act and related §460.80 of the PACE rule. Therefore, with the exception of waived requirements for PACE, specifics of §§423.401-423.425 are not summarized below.
Sec. 423.401 - General requirements for PDP sponsors *STATE LICENSURE REQUIREMENTS UNDER §423.401(a)(1)* ***WAIVED FOR PACE***	§423.401(a)(1) requiring Part D plans to be licensed under State law as risk bearing entities is waived as conflicting with PACE requirements in §460.12(b) and §460.32(a)(2).

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Sec. 423.420 - Solvency standards for non-licensed entities ***WAIVED FOR PACE***	CMS has waived Part D solvency standards for PACE as conflicting with §460.80.
Sec. 423.440 - Prohibition of State imposition of premium taxes; relation to State laws	This section states that the standards established for Part D supersede State law or regulation (other than State licensing laws or State laws relating to plan solvency). Further, States are prohibited from imposing premium taxes, fees or other similar assessments for any payment CMS makes on behalf of the Part D plan or enrollees, or for any payment made to Part D plans by a beneficiary or by a third party on behalf of a beneficiary.
Subpart J - Coordination under Part D Plans with Other Prescription Drug Coverage (pp. 4552-4553; preamble pp. 4320-4330)	
Sec. 423.452 - Scope	This section sets forth the application of Part D rules to Part C plans; establishes waivers for MA-PD plans, employer-sponsored group prescription drug plans, cost plans, and PACE organizations; and establishes requirements for coordination of benefits with State Pharmaceutical Assistance Programs (SPAPs) and other providers of prescription drug coverage.
Sec. 423.454 - Definitions	Defines employer-sponsored group and State Pharmaceutical Assistance Programs (SPAPs).
Sec. 423.458 - Application of Part D rules to certain Part D plans on and after January 1, 2006	Under §423.528(d), CMS has the authority to waive any provision of Part D as applied to a PACE organization to the extent CMS determines that the provision duplicates, or is in conflict with, provisions otherwise applicable to PACE organizations under sections 1984 and 1934 of the Social Security Act, or as necessary in order to improve coordination of Part D with the benefits offered by PACE organizations. Waivers granted to individual PACE organizations will apply to all "similarly situated" PACE organizations offering or seeking to offer Part D coverage. This is the authority which CMS has used to waive specific Part D requirements for PACE organizations referred to throughout this document. Further, PACE organizations can utilize this authority as the basis for requesting additional waivers as they identify instances in which Part D and PACE requirements are duplicative or in conflict with each other, or where waivers are needed to improve coordination of Part D and PACE benefits.
Sec. 423.462 - Medicare secondary payer procedures ***WAIVED FOR PACE***	Medicare secondary payer procedures apply consistent with current requirements of PACE organizations under §460.180(d).
Sec. 423.464 - Coordination of benefits with other providers of prescription drug coverage *§423.464(c), §423.464(f)(2) and §423.464(f)(4)* ***WAIVED FOR PACE***	A Part D plan must permit SPAPs and entities providing other prescription drug coverage to coordinate benefits with such plan. Other entities include: Medicaid programs, group health plans, the Federal Employee Health Benefits Program, military coverage, Indian Health Service, federally qualified health centers, rural health centers, and other prescription drug coverage. A Part D plan must comply with all administrative processes and requirements established by CMS to ensure effective exchange of information and coordination between such plan and SPAPs and entities providing other prescription drug coverage for (1) payment of premiums and coverage; and (2) payment for supplemental

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	prescription drug benefits for individuals enrolled in the Part D plan and the SPAP or entity providing other prescription drug coverage. With regard to Part D requirements related to coordination of benefits, requirements under §423.464(c), §423.464(f)(2) and §423.464(f)(4)) have been waived for PACE in order to promote coordination of benefits between Part D and PACE.
Subpart K - Application Procedures and Contracts with PDP Sponsors (pp. 4553-4561; preamble pp. 4330-4341)	This subpart sets forth requirements related to applications and contracts with Part D plans. CMS has waived many of the Part D application and contract requirements for PACE as either duplicative or in conflict with PACE requirements, or to improve the coordination of PACE and Part D benefits. Waiver of these requirements recognizes that PACE organizations have long provided comprehensive prescription drug coverage among their benefits, and the inclusion of prescription drugs as a PACE benefit is already recognized in the PACE application and provider application processes. The basis for waiver of the Part D requirements is that they are either in conflict with or duplicative of PACE requirements under §460.12(b),§460.32, §460.30-34, §460.50,§460.52, §460.54, §460.60-68, §460.80 and Subpart L, or waiver of the Part D requirement will promote coordination of benefits between Part D and PACE. Specific requirements within Subpart K have NOT been waived for PACE, rather they will be applied to PACE organizations as they are to other Part D plans. These include requirements that the PACE organization have: 1) procedures for effective internal monitoring and auditing; 2) procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization's contract as a Part D plan sponsor; and 3) a comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste, and abuse. Further, under §423.505(d), PACE organizations must agree to maintain, for 10 years, books, records, documents, and other evidence of accounting procedures and practices and, under §423.505(j), agree to include in their contracts with CMS other terms and conditions as CMS may find necessary and appropriate in order to implement Part D requirements. PACE organizations are also subject to requirements under §423.505(k)(1-5) related to certification of data including enrollment and payment information, claims data, bid submission information, and allowable costs for risk corridor and reinsurance information. The Abbreviated Application for PACE Organizations Offering Part D Coverage is available at www.cms.hhs.gov/pace/part_d_app.pdf. The application, along with an addendum related to security and record retention (www.cms.hhs.gov/pace/part_d_add.pdf), takes the place of the PDP and MA-PD Part D applications for PACE. In addition to the abbreviated application, PACE organizations also must submit a Signed Transition Attestation and Signed Business Integrity Attestation to CMS. These are available as attachments to a memo dated 1/21/2005 titled Guidance for PACE Organizations on how to comply with requirements established in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) relating to the Medicare prescription drug benefit. The memo is available at www.cms.hhs.gov/healthplans/madvantage/pace_transitionmemo.pdf. The memo also states CMS' requirements that PACE organizations submit Part D bids and update contact information through the Health Plan Management System (HPMS). The latter is critical as HPMS will be the system that CMS uses to support the ongoing operations of the Part D program and the vehicle by which all Part D plans, including PACE organizations, will submit contract, formulary and bid information. For assistance with HPMS issues, contact Kristin Finch at Kristin.Finch@cms.hhs.gov or (410) 786-2873.
§423.502(b)(1)(i-ii), §423.504(b)(2-3), §423.504(b)(4)(i-v) and (vi)(A-E), §423.504.(b)(5)-(d), §423.504(e),§423.505(a-c) and (e-i), §423.505(k)(6), §423.506-423.514 ***WAIVED FOR PACE***	

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	Lastly, although CMS has indicated that §423.514 is waived for PACE, it is the regulatory basis for reporting requirements that apply, in part, to PACE organizations (NPA will talk to CMS about this inconsistency). For more information regarding these requirements, refer to Final Medicare Part D Reporting Requirements at www.cms.hhs.gov/pdps/PlnRpt_Ovrsit.asp. Referring to the Medicare Part D reporting requirements, PACE organizations are required to report data on the following: Enrollment/Disenrollment; Generic Dispensing Rate; Prior Authorization, Step Edits and Non-Formulary Exception (for PACE organizations with formularies); Overpayment; and Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions.
Subpart L - Effect of Change of Ownership or Leasing of Facilities during Term of Contract (pp. 4561-4562; preamble pp. 4341-4342) ***§423.551 and §423.552 WAIVED FOR PACE***	Many of the requirements under this subpart are waived for PACE as duplicative of requirements under §460.60(d)(4) which requires changes in organization structure to be approved in advance by CMS and the State administering agency. In Subpart L, §423.553 related to leasing of a PDP sponsor's facilities does apply to PACE.
Subpart M - Grievances, Coverage Determinations and Appeals (pp. 4562-4569; preamble pp. 4342-4365) ***§423.560 - §423.638 (all of Subpart M) WAIVED FOR PACE***	CMS has waived Part D requirements in Subpart M because they conflict with or are duplicative of PACE requirements related to grievances and appeals in §460.120, §460.122 and §460.124, and waiver of the Part D requirements will promote coordination of benefits between Part D and PACE.
Subpart N - Medicare Contract Determinations and Appeals (pp. 4569-4571; preamble pp. 4365)	Subpart N establishes procedures for reviewing the following types of contract determinations: 1) a determination that an entity is not qualified to enter into a contract with CMS under Part D; 2) a determination not to authorize a renewal of a contract with a PDP sponsor; and 3) a determination to terminate a contract with a PDP sponsor. Specifically, Subpart N includes, but is not limited to, requirements for: 1) notices of contract determination; 2) requests for CMS' reconsideration of a contract determination; 3) opportunities for PDP sponsors or contract applicants to submit evidence; 4) reconsidered determinations; and rights of contract applicants and PDP sponsors to a hearing.
Subpart O - Intermediate Sanctions (pp. 4571-4572; preamble pp. 4365-4367)	
Sec. 423.750 - Kinds of sanctions	CMS may impose the following intermediate sanctions and civil money penalties: 1) civil money penalties ranging from $10,000 - $100,000; 2) suspension of enrollment; 3) suspension of payment; 4) suspension of Part D plan marketing activities. Enrollment, payment and marketing sanctions remain in effect until CMS is satisfied the deficiency is corrected and not likely to recur.
Sec. 423.752 - Basis for imposing sanctions	Sanctions may be imposed for the following: 1) fails substantially to provide medically necessary services that the organization is required to provide and that failure adversely affects the enrollee; 2) imposes premiums in excess of those permitted; 3) acts to expel or refuses to reenroll a beneficiary in violation of Part D requirements; 4) engages in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose condition indicates a need for substantial future medical services; 5) misrepresents or falsifies information furnished to CMS, or to an individual or other entity under the Part D program; 6) employs or contracts with an individual or entity

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	excluded from participation in Medicare.
Sec. 423.756 - Procedures for imposing sanctions	Requirements related to CMS' notification of sanctions and opportunities for the Part D sponsor to respond prior to imposition of the sanction. If sanction is imposed, CMS may: 1) require the Part D sponsor to suspend enrollment; 2) suspend payments; 3) require the Part D sponsor to suspend marketing activities. Sanctions are effective 15 days after the date the organization is notified of the imposition of the sanction unless the sponsor's conduct poses a serious threat to enrollees' health and safety in which case the sanction may be effective earlier. The sanction remains in effect until CMS notifies the sponsor that CMS is satisfied that the basis for imposing the sanction is corrected and not likely to recur.
Sec. 423.758 - Maximum amount of civil money penalties imposed by CMS	Specifies amounts of civil money penalties in response to specific determinations.
Subpart P - Premiums and Cost-Sharing Subsidies for Low-Income Beneficiaries (pp. 4572-4575; preamble pp. 4367-4391)	The majority of PACE enrollees will be eligible for premium and cost-sharing subsidies as a consequence of their Medicaid eligibility. In addition, Medicare-only enrollees who meet income and asset requirements are also eligible for subsidy assistance. Subpart P establishes requirements for eligibility; processes for determining eligibility; and information requiring premium and cost-sharing subsidies.
Sec. 423.773 - Requirements for eligibility	**Full subsidy-eligible individuals** meet the following requirements: ■ Have income below 135% of the federal poverty level (FPL) applicable to the individual's family size AND resources that do not exceed, for 2006, 3 times the amount of resources an individual may have and still be eligible for benefits under the Supplemental Security Income (SSI) program (for subsequent years, this amount is increased by the annual percentage increase in the consumer price index (CPI) OR ■ Are a full-benefit dual eligible individual OR ■ Are a recipient of SSI benefits under title XVI of the Social Security Act OR ■ Are eligible for Medicaid as a Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) or a Qualifying Individual (QI) under a State's plan. **Other low-income subsidy individuals** meet the following requirements: ■ Have income below 150% of the FPL applicable to the individual's family size AND resources that do not exceed, for 2006, $10,000 if single or $20,000 if married (for subsequent years, this amount is increased by the annual percentage increase in the CPI)
Sec. 423.774 - Eligibility determinations, redeterminations and applications	If an individual is eligible for Medicaid or SSI, he/she will be notified by CMS of their eligibility for a full Part D subsidy and does not need to apply for the subsidy. For other beneficiaries, determinations of eligibility for subsidies are made by the State if the individual applies with the Medicaid agency or by the Commissioner of Social Security if the individual applies with the Social Security Administration. Initial determinations are effective beginning with the 1st date of the month in which the individual applies, but

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	no earlier than January 1, 2006 and remain in effect for a period not to exceed 1 year.
Sec. 423.780 - Premium subsidy	Full subsidy eligible individuals, including dual eligible enrollees, are entitled to a premium subsidy equal to 100% of the premium subsidy amount (defined at §423.780(b)). In addition, for Medicaid-eligible PACE enrollees, if the premium subsidy amount is less than the beneficiary premium for the PACE organization's Part D plan, CMS will pay the difference (see p. 59 of the 45-Day Notice of Payment at www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf). Other low-income subsidy eligible individuals are entitled to a premium subsidy based on a sliding scale as follows: ■ for individuals with income at or below 135% of the FPL, 100% of the premium subsidy amount ■ for individuals with income greater than 135% but at or below 140% of the FPL, premium subsidy equal to 75% of the premium subsidy amount ■ for individuals with income greater than 140% but at or below 145% of the FPL, premium subsidy equal to 50% of the premium subsidy amount ■ for individuals with income greater than 145% but at or below 150% of the FPL, premium subsidy equal to 25% of the premium subsidy amount
Sec. 423.782 - Cost-sharing subsidy	Full subsidy eligible individuals, including dual eligible enrollees, are entitled to the following: ■ elimination of annual Part D deductiblen ■ reduction in cost-sharing ■ if dual eligible and institutionalized, $0 co-payment ■ if non-institutionalized dual eligible with income less than or equal to $100% of FPL, not to exceed $1 generic/preferred multiple source and $3 other for drugs up to out-of-pocket limit*; $0 above out-of-pocket limit ■ if non-institutionalized dual eligible with income greater than $100% of FPL, not to exceed $2 generic/preferred multiple source and $5 other for drugs up to out-of-pocket limit*; $0 above out-of-pocket limit ■ for non-dual eligibles with income less than 135% of FPL and assets that do not exceed $6,000/$9,000 limit, not to exceed $2 generic/preferred multiple source and $5 other drugs up to out-of-pocket limit*; $0 above out-of-pocket limit Other low-income subsidy eligible individuals are entitled to the following: ■ reduction of annual deductible to $50 ■ 15% coinsurance for all covered Part D drugs after the annual deductible up to the out-of-pocket limit ■ Co-payments not to exceed $2 for a generic/preferred multiple source and $5 for any other drug for covered drugs above the out-of-pocket limit.* * For PACE organizations that are not allowed to charge co-payment amounts, for dual eligbiles, CMS will make payments to PACE organizations covering these amounts as described on pp. 58-59 of the 45-Day Notice of Payment at www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf. All co-payment amounts for Medicare-only PACE enrollees must be included in enrollees' supplemental premiums.

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Subpart Q - Guaranteeing Access to a Choice of Coverage (Fallback prescription drug plans) (pp. 4575-4577; preamble pp. 4391-4400)	Subpart Q does not apply to PACE organizations.
Subpart R - Payments to Sponsors of Retiree Prescription Drug Plans (pp. 4577-4582; preamble pp. 4400-4417)	Subpart R does not apply to PACE organizations.
Subpart S - Special Rules for States - Eligibility Determinations for Subsidies and General Provisions (pp. 4582-4585; preamble pp. 4417-4424)	Subpart S is directed to States and specifies State agency obligations for the Part D prescription drug benefit. Specifically, Subpart S: 1) establishes States' obligations with respect to eligibility determinations and redeterminations for low-income premium and cost-sharing subsidies; 2) states that Medicaid is not available to dual eligibles for covered part D drugs or any cost-sharing obligations under Part D relating to covered Part D drugs; 3) affirms that States may provide coverage for outpatient drugs not covered under Part D; 4) sets forth requirements for State contributions for Part D drug benefits (the "clawback").
Subpart T - (preamble only pp. 4424-4438; specific section on PACE pp. 4426-4434)	Subpart T does not appear in the regulation itself, i.e., outside the preamble. Beginning on p. 4426 there is a discussion specific to PACE. After summarizing the approach that CMS took towards PACE in the NPRM as well as the comments received in response to the NPRM, CMS indicates how it plans to handle bidding and payment for PACE organizations under Part D. First, PACE organizations will be required to submit a Part D bid, although the deadline for bid submission under §423.265(b) is waived for PACE organizations such that bids are expected, but not required, to be submitted by June 6, 2006 (for more information on bidding, refer to Subpart F on pp. 8-10. To the extent an existing PACE organization cannot meet the June 5, 2005 deadline, it will be extended. Further, prospective PACE organizations will not be bound by the annual bid deadline of the first Monday in June. Importantly, in the final rule, CMS recognizes that conflicting PACE and Part D requirements related to beneficiary cost sharing and the PACE preclusion of charging any Medicaid eligible a premium will result in a "significant Part D payment discrepancy to PACE organizations absent our intervention." Consequently, CMS is considering adjusting Part D payments to PACE organizations under its authority in 1894(d)(2) of the Social Security Act and §460.180(b)(5). Specificity regarding these payment adjustments is in the 45 Day Notice of Payment (pp. 58-59 of http://www.cms.hhs.gov/healthplans/rates/2006/45-day.pdf). Other waivers of Part D requirements for PACE organizations are identified throughout this document.

The overall objective of this document is to discuss the implications of Part D from the perspective of PACE organizations. In addition, the document includes references to numerous, important guidances and materials that CMS has issued related to Part D implementation and payment.

Appendix D

PACE Eligible Demographic Market Assessment Table for Fairfax

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Arlington County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51013100100	578	578	50	8.65%	101	17.47%	42	7.27%	367	23	6.27%	50	101	42	3	6	3
51013100200	874	874	88	10.07%	99	11.33%	88	10.07%	640	29	4.53%	88	99	88	4	4	4
51013100300	974	974	63	6.47%	133	13.66%	63	6.47%	656	17	2.59%	63	133	63	2	3	2
51013100400	650	650	39	6.00%	62	9.54%	39	6.00%	419	9	2.15%	39	62	39	1	1	1
51013100500	437	437	35	8.01%	99	22.65%	35	8.01%	277	15	5.42%	35	99	35	2	5	2
51013100600	444	254	13	5.12%	34	13.39%	13	5.12%	170	21	12.35%	23	59	23	3	7	3
51013100700	537	473	33	6.98%	95	20.08%	33	6.98%	287	73	25.44%	37	108	37	10	27	10
51013100800	226	226	21	9.29%	86	38.05%	21	9.29%	162	37	22.84%	21	86	21	5	20	5
51013100900	378	378	35	9.26%	70	18.52%	35	9.26%	247	34	13.77%	35	70	35	5	10	5
51013101000	281	281	20	7.12%	68	24.20%	20	7.12%	195	34	17.44%	20	68	20	3	12	3
51013101100	452	452	20	4.42%	92	20.35%	20	4.42%	301	10	3.32%	20	92	20	1	3	1
51013101200	753	696	72	10.34%	153	21.98%	72	10.34%	500	140	28.00%	78	166	78	22	46	22
51013101300	581	581	63	10.84%	149	25.65%	63	10.84%	405	32	7.90%	63	149	63	5	12	5
51013101400	1030	856	113	13.20%	183	21.38%	113	13.20%	686	33	4.81%	136	220	136	7	11	7
51013101500	451	451	18	3.99%	69	15.30%	18	3.99%	351	29	8.26%	18	69	18	1	6	1
51013101600	301	301	20	6.64%	38	12.62%	20	6.64%	242	48	19.83%	20	38	20	4	8	4
51013101700	382	382	20	5.24%	73	19.11%	20	5.24%	298	57	19.13%	20	73	20	4	14	4
51013101800	341	329	7	2.13%	61	18.54%	7	2.13%	237	42	17.72%	7	63	7	1	11	1
51013101900	170	170	28	16.47%	27	15.88%	28	16.47%	101	6	5.94%	28	27	28	2	2	2
51013102000	818	804	82	10.20%	190	23.63%	77	9.58%	708	270	38.14%	83	193	78	32	74	30
51013102100	542	417	67	16.07%	86	20.62%	62	14.87%	287	162	56.45%	87	112	81	49	63	45
51013102200	299	299	29	9.70%	61	20.40%	29	9.70%	209	40	19.14%	29	61	29	6	12	6
51013102300	466	466	24	5.15%	89	19.10%	24	5.15%	291	8	2.75%	24	89	24	1	2	1
51013102400	259	233	16	6.87%	39	16.74%	16	6.87%	182	28	15.38%	18	43	18	3	7	3
51013102500	322	322	20	6.21%	79	24.53%	20	6.21%	240	38	15.83%	20	79	20	3	13	3
51013102600	170	170	11	6.47%	43	25.29%	11	6.47%	145	22	15.17%	11	43	11	2	7	2
51013102700	126	126	0	0.00%	23	18.25%	0	0.00%	98	13	13.27%	0	23	0	0	3	0

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Arlington County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51013102800	550	550	87	15.82%	123	22.36%	87	15.82%	354	59	16.67%	87	123	87	15	21	15
51013102900	131	131	0	0.00%	15	11.45%	0	0.00%	99	15	15.15%	0	15	0	0	2	0
51013103000	188	188	11	5.85%	11	5.85%	11	5.85%	153	5	3.27%	11	11	11	0	0	0
51013103100	488	488	78	15.98%	154	31.56%	71	14.55%	309	61	19.74%	78	154	71	15	30	14
51013103200	392	392	23	5.87%	57	14.54%	23	5.87%	295	39	13.22%	23	57	23	3	8	3
51013103300	197	197	73	37.06%	40	20.30%	73	37.06%	114	48	42.11%	73	40	73	31	17	31
51013103401	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51013103402	418	418	20	4.78%	54	12.92%	20	4.78%	307	15	4.89%	20	54	20	1	3	1
51013103500	1181	997	60	6.02%	164	16.45%	60	6.02%	824	325	39.44%	71	194	71	28	77	28
51013103600	299	299	0	0.00%	30	10.03%	0	0.00%	229	0	0.00%	0	30	0	0	0	0
51013103700	344	344	6	1.74%	25	7.27%	6	1.74%	208	0	0.00%	6	25	6	0	0	0
51013103800	185	185	16	8.65%	18	9.73%	16	8.65%	101	25	24.75%	16	18	16	4	4	4
TOTAL	**17215**	**16369**	**1381**		**2993**		**1356**		**11694**	**1862**		**1459**	**3147**	**1432**	**275**	**550**	**267**

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Alexandria City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51510200101	1179	697	69	9.90%	222	31.85%	69	9.90%	576	107	18.58%	117	376	117	22	70	22
51510200102	217	217	6	2.76%	28	12.90%	6	2.76%	129	7	5.43%	6	28	6	0	2	0
51510200103	317	317	21	6.62%	85	26.81%	21	6.62%	217	12	5.53%	21	85	21	1	5	1
51510200104	60	60	0	0.00%	33	55.00%	0	0.00%	33	4	12.12%	0	33	0	0	4	0
51510200105	270	270	47	17.41%	87	32.22%	47	17.41%	155	23	14.84%	47	87	47	7	13	7
51510200201	304	287	25	8.71%	38	13.24%	25	8.71%	203	41	20.20%	26	40	26	5	8	5
51510200202	285	279	15	5.38%	20	7.17%	15	5.38%	151	11	7.28%	15	20	15	1	1	1
51510200301	192	192	11	5.73%	27	14.06%	11	5.73%	124	9	7.26%	11	27	11	1	2	1
51510200302	432	432	47	10.88%	62	14.35%	47	10.88%	272	12	4.41%	47	62	47	2	3	2
51510200303	706	706	66	9.35%	194	27.48%	66	9.35%	594	359	60.44%	66	194	66	40	117	40
51510200401	212	212	11	5.19%	32	15.09%	6	2.83%	138	0	0.00%	11	32	6	0	0	0
51510200402	872	872	42	4.82%	184	21.10%	42	4.82%	648	62	9.57%	42	184	42	4	18	4
51510200500	368	368	28	7.61%	79	21.47%	28	7.61%	303	142	46.86%	28	79	28	13	37	13
51510200600	469	384	64	16.67%	79	20.57%	64	16.67%	233	11	4.72%	78	96	78	4	5	4
51510200700	402	402	50	12.44%	103	25.62%	50	12.44%	299	77	25.75%	50	103	50	13	27	13
51510200801	422	422	11	2.61%	56	13.27%	11	2.61%	283	9	3.18%	11	56	11	0	2	0
51510200802	193	193	11	5.70%	29	15.03%	11	5.70%	146	14	9.59%	11	29	11	1	3	1
51510200900	641	576	42	7.29%	92	15.97%	42	7.29%	391	19	4.86%	47	102	47	2	5	2
51510201000	222	222	13	5.86%	44	19.82%	13	5.86%	155	22	14.19%	13	44	13	2	6	2
51510201100	262	262	18	6.87%	18	6.87%	18	6.87%	159	0	0.00%	18	18	18	0	0	0
51510201202	170	170	29	17.06%	25	14.71%	29	17.06%	116	9	7.76%	29	25	29	2	2	2
51510201203	115	115	7	6.09%	35	30.43%	7	6.09%	38	6	15.79%	7	35	7	1	6	1
51510201204	193	193	14	7.25%	43	22.28%	14	7.25%	136	34	25.00%	14	43	14	4	11	4
51510201300	334	334	28	8.38%	49	14.67%	28	8.38%	241	72	29.88%	28	49	28	8	15	8
51510201400	266	266	16	6.02%	70	26.32%	16	6.02%	197	39	19.80%	16	70	16	3	14	3
51510201500	539	287	19	6.62%	36	12.54%	13	4.53%	197	31	15.74%	36	68	24	6	11	4
51510201600	291	291	15	5.15%	73	25.09%	15	5.15%	176	46	26.14%	15	73	15	4	19	4
51510201801	567	567	55	9.70%	84	14.81%	55	9.70%	495	231	46.67%	55	84	55	26	39	26

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Alexandria City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51510201802	188	188	0	0.00%	19	10.11%	0	0.00%	153	14	9.15%	0	19	0	0	2	0
51510201900	117	117	6	5.13%	6	5.13%	6	5.13%	88	12	13.64%	6	6	6	1	1	1
51510202001	313	313	6	1.92%	14	4.47%	6	1.92%	222	8	3.60%	6	14	6	0	1	0
51510202002	275	275	10	3.64%	18	6.55%	10	3.64%	227	24	10.57%	10	18	10	1	2	1
TOTAL	**11393**	**10486**	**802**		**1984**		**791**		**7495**	**1467**		**887**	**2200**	**871**	**174**	**447**	**173**

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Falls Church City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51610500100	321	321	29	9.03%	46	14.33%	29	9.03%	221	16	7.24%	29	46	29	2	3	2
51610500200	518	518	53	10.23%	96	18.53%	53	10.23%	366	74	20.22%	53	96	53	11	19	11
51610500300	439	370	13	3.51%	55	14.86%	6	1.62%	272	21	7.72%	15	65	7	1	5	1
TOTAL	**1278**	**1209**	**95**		**197**		**88**		**859**	**111**		**97**	**207**	**89**	**14**	**28**	**13**

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51600300100	534	534	39	7.30%	77	14.42%	39	7.30%	358	36	10.06%	39	77	39	4	8	4
51600300200	710	710	64	9.01%	132	18.59%	64	9.01%	467	6	1.28%	64	132	64	1	2	1
51600300300	495	495	14	2.83%	41	8.28%	14	2.83%	293	19	6.48%	14	41	14	1	3	1
51600300400	525	291	13	4.47%	60	20.62%	13	4.47%	174	22	12.64%	23	108	23	3	14	3
51600300500	451	356	27	7.58%	51	14.33%	27	7.58%	255	8	3.14%	34	65	34	1	2	1
TOTAL	**2715**	**2386**	**157**		**361**		**157**		**1547**	**91**		**175**	**423**	**175**	**10**	**28**	**10**

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059415100	465	465	33	7.10%	86	18.49%	33	7.10%	290	32	11.03%	33	86	33	4	9	4
51059415200	451	451	8	1.77%	36	7.98%	8	1.77%	342	57	16.67%	8	36	8	1	6	1
51059415300	532	532	107	20.11%	138	25.94%	107	20.11%	353	60	17.00%	107	138	107	18	23	18
51059415400	762	762	38	4.99%	41	5.38%	38	4.99%	492	22	4.47%	38	41	38	2	2	2
51059415500	998	844	38	4.50%	152	18.01%	31	3.67%	536	122	22.76%	45	180	37	10	41	8
51059415600	635	635	36	5.67%	42	6.61%	36	5.67%	446	36	8.07%	36	42	36	3	3	3
51059415700	679	679	33	4.86%	78	11.49%	33	4.86%	402	12	2.99%	33	78	33	1	2	1
51059415800	750	750	26	3.47%	46	6.13%	26	3.47%	465	0	0.00%	26	46	26	0	0	0
51059415900	589	589	25	4.24%	80	13.58%	25	4.24%	352	7	1.99%	25	80	25	0	2	0
51059416000	432	432	29	6.71%	51	11.81%	29	6.71%	248	28	11.29%	29	51	29	3	6	3
51059416100	672	672	85	12.65%	94	13.99%	85	12.65%	371	23	6.20%	85	94	85	5	6	5
51059416200	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059416300	214	214	40	18.69%	40	18.69%	40	18.69%	133	0	0.00%	40	40	40	0	0	0
51059420100	418	418	0	0.00%	25	5.98%	0	0.00%	258	8	3.10%	0	25	0	0	1	0
51059420200	440	436	49	11.24%	85	19.50%	49	11.24%	232	7	3.02%	49	86	49	1	3	1
51059420300	531	531	14	2.64%	61	11.49%	14	2.64%	373	20	5.36%	14	61	14	1	3	1
51059420400	151	151	19	12.58%	17	11.26%	19	12.58%	114	19	16.67%	19	17	19	3	3	3
51059420500	787	787	68	8.64%	86	10.93%	68	8.64%	555	35	6.31%	68	86	68	4	5	4
51059420600	281	281	12	4.27%	78	27.76%	12	4.27%	141	15	10.64%	12	78	12	1	8	1
51059420700	519	519	27	5.20%	68	13.10%	27	5.20%	323	16	4.95%	27	68	27	1	3	1
51059420800	510	510	18	3.53%	68	13.33%	18	3.53%	295	19	6.44%	18	68	18	1	4	1
51059421000	517	429	52	12.12%	77	17.95%	52	12.12%	296	21	7.09%	63	93	63	4	7	4
51059421100	437	437	16	3.66%	58	13.27%	16	3.66%	221	0	0.00%	16	58	16	0	0	0
51059421200	239	239	13	5.44%	37	15.48%	13	5.44%	135	5	3.70%	13	37	13	0	1	0
51059421300	192	192	16	8.33%	20	10.42%	16	8.33%	111	5	4.50%	16	20	16	1	1	1
51059421400	350	350	41	11.71%	83	23.71%	41	11.71%	226	70	30.97%	41	83	41	13	26	13
51059421500	392	392	29	7.40%	86	21.94%	29	7.40%	246	53	21.54%	29	86	29	6	19	6
51059421600	179	179	20	11.17%	25	13.97%	20	11.17%	102	25	24.51%	20	25	20	5	6	5

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059421700	543	541	22	4.07%	111	20.52%	22	4.07%	302	12	3.97%	22	111	22	1	4	1
51059421800	200	200	13	6.50%	37	18.50%	13	6.50%	136	28	20.59%	13	37	13	3	8	3
51059421900	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059422000	689	607	61	10.05%	97	15.98%	61	10.05%	428	17	3.97%	69	110	69	3	4	3
51059422100	292	237	14	5.91%	39	16.46%	14	5.91%	134	15	11.19%	17	48	17	2	5	2
51059422200	25	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059422300	376	376	31	8.24%	40	10.64%	31	8.24%	229	21	9.17%	31	40	31	3	4	3
51059422400	316	316	46	14.56%	111	35.13%	46	14.56%	200	19	9.50%	46	111	46	4	11	4
51059430100	504	504	33	6.55%	68	13.49%	33	6.55%	280	15	5.36%	33	68	33	2	4	2
51059430200	674	674	29	4.30%	125	18.55%	29	4.30%	344	8	2.33%	29	125	29	1	3	1
51059430400	807	807	46	5.70%	97	12.02%	46	5.70%	477	14	2.94%	46	97	46	1	3	1
51059430500	190	190	0	0.00%	0	0.00%	0	0.00%	112	0	0.00%	0	0	0	0	0	0
51059430600	515	515	39	7.57%	126	24.47%	39	7.57%	317	42	13.25%	39	126	39	5	17	5
51059430700	339	339	53	15.63%	76	22.42%	53	15.63%	248	38	15.32%	53	76	53	8	12	8
51059430800	977	977	59	6.04%	117	11.98%	59	6.04%	597	25	4.19%	59	117	59	2	5	2
51059430900	328	328	38	11.59%	73	22.26%	38	11.59%	159	0	0.00%	38	73	38	0	0	0
51059431000	339	339	27	7.96%	52	15.34%	27	7.96%	155	13	8.39%	27	52	27	2	4	2
51059431300	330	330	7	2.12%	43	13.03%	7	2.12%	177	9	5.08%	7	43	7	0	2	0
51059431400	342	342	18	5.26%	36	10.53%	18	5.26%	199	7	3.52%	18	36	18	1	1	1
51059431500	528	528	25	4.73%	51	9.66%	25	4.73%	320	5	1.56%	25	51	25	0	1	0
51059431600	849	849	31	3.65%	148	17.43%	31	3.65%	539	26	4.82%	31	148	31	1	7	1
51059431800	371	371	36	9.70%	50	13.48%	36	9.70%	204	15	7.35%	36	50	36	3	4	3
51059431900	186	186	5	2.69%	26	13.98%	5	2.69%	89	6	6.74%	5	26	5	0	2	0
51059432000	106	106	7	6.60%	25	23.58%	7	6.60%	53	5	9.43%	7	25	7	1	2	1
51059432100	222	222	21	9.46%	30	13.51%	21	9.46%	154	21	13.64%	21	30	21	3	4	3
51059432200	592	356	34	9.55%	98	27.53%	34	9.55%	235	63	26.81%	57	163	57	15	44	15
51059432300	324	324	35	10.80%	65	20.06%	35	10.80%	174	70	40.23%	35	65	35	14	26	14
51059432400	331	331	31	9.37%	92	27.79%	31	9.37%	153	8	5.23%	31	92	31	2	5	2
51059432500	180	180	15	8.33%	44	24.44%	15	8.33%	91	0	0.00%	15	44	15	0	0	0

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059432600	92	92	14	15.22%	20	21.74%	14	15.22%	43	5	11.63%	14	20	14	2	2	2
51059432700	344	344	23	6.69%	73	21.22%	23	6.69%	176	0	0.00%	23	73	23	0	0	0
51059432800	101	101	4	3.96%	12	11.88%	4	3.96%	48	10	20.83%	4	12	4	1	3	1
51059440100	1488	1142	71	6.22%	242	21.19%	71	6.22%	813	52	6.40%	93	315	93	6	20	6
51059440200	368	368	20	5.43%	54	14.67%	20	5.43%	259	48	18.53%	20	54	20	4	10	4
51059440300	375	375	19	5.07%	34	9.07%	19	5.07%	227	12	5.29%	19	34	19	1	2	1
51059440500	672	672	24	3.57%	69	10.27%	24	3.57%	373	7	1.88%	24	69	24	0	1	0
51059440600	225	225	19	8.44%	26	11.56%	19	8.44%	149	19	12.75%	19	26	19	2	3	2
51059440700	1031	1031	64	6.21%	104	10.09%	64	6.21%	635	30	4.72%	64	104	64	3	5	3
51059440800	1012	1012	63	6.23%	174	17.19%	63	6.23%	636	72	11.32%	63	174	63	7	20	7
51059450100	281	281	22	7.83%	29	10.32%	22	7.83%	183	24	13.11%	22	29	22	3	4	3
51059450200	371	371	36	9.70%	91	24.53%	36	9.70%	236	51	21.61%	36	91	36	8	20	8
51059450300	451	451	11	2.44%	39	8.65%	11	2.44%	326	63	19.33%	11	39	11	2	8	2
51059450400	380	380	25	6.58%	74	19.47%	25	6.58%	235	20	8.51%	25	74	25	2	6	2
51059450500	219	219	30	13.70%	46	21.00%	30	13.70%	138	19	13.77%	30	46	30	4	6	4
51059450600	787	787	85	10.80%	144	18.30%	85	10.80%	515	41	7.96%	85	144	85	7	11	7
51059450700	540	540	70	12.96%	130	24.07%	70	12.96%	270	17	6.30%	70	130	70	4	8	4
51059450800	511	511	5	0.98%	55	10.76%	5	0.98%	332	48	14.46%	5	55	5	1	8	1
51059450900	221	221	10	4.52%	31	14.03%	10	4.52%	151	27	17.88%	10	31	10	2	6	2
51059451000	596	397	28	7.05%	45	11.34%	28	7.05%	234	4	1.71%	42	68	42	1	1	1
51059451100	395	395	39	9.87%	59	14.94%	39	9.87%	253	0	0.00%	39	59	39	0	0	0
51059451200	338	338	12	3.55%	31	9.17%	12	3.55%	224	0	0.00%	12	31	12	0	0	0
51059451300	310	310	21	6.77%	67	21.61%	21	6.77%	226	0	0.00%	21	67	21	0	0	0
51059451400	173	173	3	1.73%	8	4.62%	3	1.73%	98	35	35.71%	3	8	3	1	3	1
51059451500	1133	1075	100	9.30%	205	19.07%	100	9.30%	709	138	19.46%	105	216	105	21	42	21
51059451600	424	424	31	7.31%	109	25.71%	18	4.25%	280	17	6.07%	31	109	18	2	7	1
51059451800	425	425	32	7.53%	70	16.47%	32	7.53%	293	6	2.05%	32	70	32	1	1	1
51059451900	481	434	29	6.68%	56	12.90%	29	6.68%	252	38	15.08%	32	62	32	5	9	5
51059452000	528	528	62	11.74%	125	23.67%	62	11.74%	408	183	44.85%	62	125	62	28	56	28

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059452100	959	821	10	1.22%	151	18.39%	10	1.22%	513	75	14.62%	12	176	12	2	26	2
51059452200	619	619	39	6.30%	51	8.24%	39	6.30%	320	19	5.94%	39	51	39	2	3	2
51059452300	458	458	75	16.38%	106	23.14%	66	14.41%	280	36	12.86%	75	106	66	10	14	8
51059452400	710	710	149	20.99%	185	26.06%	149	20.99%	389	28	7.20%	149	185	149	11	13	11
51059452500	787	734	45	6.13%	121	16.49%	45	6.13%	382	52	13.61%	48	130	48	7	18	7
51059452600	324	324	31	9.57%	30	9.26%	31	9.57%	218	43	19.72%	31	30	31	6	6	6
51059452700	279	279	15	5.38%	55	19.71%	15	5.38%	182	55	30.22%	15	55	15	5	17	5
51059452800	1244	1244	85	6.83%	171	13.75%	85	6.83%	893	70	7.84%	85	171	85	7	13	7
51059460100	346	346	13	3.76%	23	6.65%	13	3.76%	205	9	4.39%	13	23	13	1	1	1
51059460200	370	370	25	6.76%	44	11.89%	25	6.76%	197	0	0.00%	25	44	25	0	0	0
51059460300	289	289	6	2.08%	30	10.38%	6	2.08%	174	7	4.02%	6	30	6	0	1	0
51059460400	750	750	48	6.40%	147	19.60%	48	6.40%	526	235	44.68%	48	147	48	21	66	21
51059460500	414	414	20	4.83%	57	13.77%	20	4.83%	216	23	10.65%	20	57	20	2	6	2
51059460600	616	557	54	9.69%	57	10.23%	54	9.69%	350	14	4.00%	60	63	60	2	3	2
51059460700	904	904	39	4.31%	120	13.27%	39	4.31%	583	15	2.57%	39	120	39	1	3	1
51059460800	356	213	19	8.92%	46	21.60%	19	8.92%	248	10	4.03%	32	77	32	1	3	1
51059460900	300	135	12	8.89%	35	25.93%	12	8.89%	183	5	2.73%	27	78	27	1	2	1
51059461000	272	155	17	10.97%	80	51.61%	17	10.97%	180	35	19.44%	30	140	30	6	27	6
51059461100	839	410	24	5.85%	111	27.07%	24	5.85%	440	16	3.64%	49	227	49	2	8	2
51059461200	451	219	13	5.94%	27	12.33%	13	5.94%	266	16	6.02%	27	56	27	2	3	2
51059461500	317	181	62	34.25%	65	35.91%	62	34.25%	151	17	11.26%	109	114	109	12	13	12
51059461600	408	224	39	17.41%	51	22.77%	39	17.41%	250	8	3.20%	71	93	71	2	3	2
51059461700	376	193	36	18.65%	43	22.28%	36	18.65%	238	6	2.52%	70	84	70	2	2	2
51059461800	310	191	9	4.71%	30	15.71%	9	4.71%	217	24	11.06%	15	49	15	2	5	2
51059461900	336	187	38	20.32%	75	40.11%	38	20.32%	168	43	25.60%	68	135	68	17	34	17
51059470100	340	161	40	24.84%	73	45.34%	40	24.84%	205	12	5.85%	84	154	84	5	9	5
51059470200	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059470300	527	253	29	11.46%	85	33.60%	22	8.70%	322	6	1.86%	60	177	46	1	3	1
51059470400	731	396	29	7.32%	64	16.16%	29	7.32%	432	18	4.17%	54	118	54	2	5	2

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059470500	822	468	39	8.33%	87	18.59%	39	8.33%	545	49	8.99%	69	153	69	6	14	6
51059470600	458	307	62	20.20%	100	32.57%	56	18.24%	322	56	17.39%	92	149	84	16	26	15
51059470700	773	430	11	2.56%	66	15.35%	11	2.56%	512	7	1.37%	20	119	20	0	2	0
51059470800	450	243	39	16.05%	31	12.76%	39	16.05%	290	23	7.93%	72	57	72	6	5	6
51059470900	1068	514	65	12.65%	118	22.96%	65	12.65%	631	70	11.09%	135	245	135	15	27	15
51059471000	226	128	16	12.50%	36	28.13%	16	12.50%	157	0	0.00%	28	64	28	0	0	0
51059471100	736	396	28	7.07%	99	25.00%	28	7.07%	454	48	10.57%	52	184	52	6	19	6
51059471200	554	331	31	9.37%	39	11.78%	31	9.37%	415	48	11.57%	52	65	52	6	8	6
51059471300	651	365	93	25.48%	145	39.73%	93	25.48%	360	37	10.28%	166	259	166	17	27	17
51059471400	510	307	44	14.33%	84	27.36%	44	14.33%	323	16	4.95%	73	140	73	4	7	4
51059480100	349	181	25	13.81%	24	13.26%	25	13.81%	235	24	10.21%	48	46	48	5	5	5
51059480200	1145	657	48	7.31%	114	17.35%	48	7.31%	736	51	6.93%	84	199	84	6	14	6
51059480300	659	312	57	18.27%	48	15.38%	57	18.27%	434	9	2.07%	120	101	120	2	2	2
51059480400	619	296	42	14.19%	75	25.34%	42	14.19%	361	19	5.26%	88	157	88	5	8	5
51059480500	383	192	30	15.63%	108	56.25%	30	15.63%	189	29	15.34%	60	215	60	9	33	9
51059480800	327	206	9	4.37%	57	27.67%	9	4.37%	180	32	17.78%	14	90	14	3	16	3
51059480900	508	294	70	23.81%	104	35.37%	70	23.81%	286	65	22.73%	121	180	121	27	41	27
51059481000	132	73	0	0.00%	5	6.85%	0	0.00%	63	0	0.00%	0	9	0	0	0	0
51059481100	402	246	34	13.82%	72	29.27%	34	13.82%	209	18	8.61%	56	118	56	5	10	5
51059481200	259	140	9	6.43%	46	32.86%	9	6.43%	124	30	24.19%	17	85	17	4	21	4
51059481400	689	432	60	13.89%	152	35.19%	60	13.89%	459	191	41.61%	96	242	96	40	101	40
51059481500	162	74	12	16.22%	37	50.00%	12	16.22%	102	0	0.00%	26	81	26	0	0	0
51059481600	233	89	13	14.61%	21	23.60%	13	14.61%	142	3	2.11%	34	55	34	1	1	1
51059481700	419	224	25	11.16%	57	25.45%	25	11.16%	260	21	8.08%	47	107	47	4	9	4
51059481900	472	222	91	40.99%	102	45.95%	91	40.99%	229	65	28.38%	193	217	193	55	62	55
51059482000	428	228	8	3.51%	55	24.12%	8	3.51%	343	43	12.54%	15	103	15	2	13	2
51059482100	283	144	15	10.42%	41	28.47%	15	10.42%	227	20	8.81%	29	81	29	3	7	3
51059482200	872	455	76	16.70%	142	31.21%	76	16.70%	480	132	27.50%	146	272	146	40	75	40
51059482300	731	420	26	6.19%	82	19.52%	26	6.19%	487	22	4.52%	45	143	45	2	6	2

Conservative Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059482400	188	112	4	3.57%	6	5.36%	4	3.57%	109	14	12.84%	7	10	7	1	1	1
51059482500	290	161	13	8.07%	83	51.55%	13	8.07%	133	0	0.00%	23	150	23	0	0	0
51059482600	397	220	0	0.00%	82	37.27%	0	0.00%	249	47	18.88%	0	148	0	0	28	0
51059490100	505	356	70	19.66%	151	42.42%	70	19.66%	300	89	29.67%	99	214	99	29	64	29
51059490500	419	241	23	9.54%	61	25.31%	23	9.54%	234	16	6.84%	40	106	40	3	7	3
51059490900	1	1	0	0.00%	0	0.00%	0	0.00%	1	0	0.00%	0	0	0	0	0	0
51059491000	145	70	11	15.71%	30	42.86%	11	15.71%	69	8	11.59%	23	62	23	3	7	3
51059491100	452	226	11	4.87%	78	34.51%	11	4.87%	182	10	5.49%	22	156	22	1	9	1
51059491200	126	67	7	10.45%	7	10.45%	7	10.45%	55	8	14.55%	13	13	13	2	2	2
51059491300	298	173	25	14.45%	37	21.39%	25	14.45%	140	25	17.86%	43	64	43	8	11	8
51059491400	340	202	27	13.37%	85	42.08%	27	13.37%	128	0	0.00%	45	143	45	0	0	0
51059491500	290	166	54	32.53%	73	43.98%	54	32.53%	161	17	10.56%	94	128	94	10	13	10
51059491600	323	184	43	23.37%	102	55.43%	22	11.96%	195	48	24.62%	75	179	39	19	44	10
51059491700	559	286	38	13.29%	89	31.12%	38	13.29%	237	41	17.30%	74	174	74	13	30	13
51059491800	688	389	67	17.22%	82	21.08%	67	17.22%	429	41	9.56%	118	145	118	11	14	11
51059491900	288	153	33	21.57%	67	43.79%	33	21.57%	148	18	12.16%	62	126	62	8	15	8
51059492000	618	287	92	32.06%	117	40.77%	92	32.06%	328	24	7.32%	198	252	198	14	18	14
51059492100	473	212	25	11.79%	45	21.23%	25	11.79%	268	6	2.24%	56	100	56	1	2	1
51059492200	676	335	69	20.60%	142	42.39%	69	20.60%	278	0	0.00%	139	287	139	0	0	0
51059492300	38	31	0	0.00%	0	0.00%	0	0.00%	15	0	0.00%	0	0	0	0	0	0
51059492400	63	31	8	25.81%	32	103.23%	8	25.81%	31	0	0.00%	16	65	16	0	0	0
TOTAL	**75998**	**61587**	**5359**		**11506**		**5296**		**45259**	**4642**		**7244**	**15448**	**7154**	**825**	**1765**	**811**

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Arlington County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51013100100	578	578	50	8.65%	101	17.47%	42	7.27%	367	23	6.27%	50	101	42	3	6	3
51013100200	874	874	88	10.07%	99	11.33%	88	10.07%	640	29	4.53%	88	99	88	4	4	4
51013100300	974	974	63	6.47%	133	13.66%	63	6.47%	656	17	2.59%	63	133	63	2	3	2
51013100400	650	650	39	6.00%	62	9.54%	39	6.00%	419	9	2.15%	39	62	39	1	1	1
51013100500	437	437	35	8.01%	99	22.65%	35	8.01%	277	15	5.42%	35	99	35	2	5	2
51013100600	444	254	13	5.12%	34	13.39%	13	5.12%	170	21	12.35%	23	59	23	3	7	3
51013100700	537	473	33	6.98%	95	20.08%	33	6.98%	287	73	25.44%	37	108	37	10	27	10
51013100800	226	226	21	9.29%	86	38.05%	21	9.29%	162	37	22.84%	21	86	21	5	20	5
51013100900	378	378	35	9.26%	70	18.52%	35	9.26%	247	34	13.77%	35	70	35	5	10	5
51013101000	281	281	20	7.12%	68	24.20%	20	7.12%	195	34	17.44%	20	68	20	3	12	3
51013101100	452	452	20	4.42%	92	20.35%	20	4.42%	301	10	3.32%	20	92	20	1	3	1
51013101200	753	696	72	10.34%	153	21.98%	72	10.34%	500	140	28.00%	78	166	78	22	46	22
51013101300	581	581	63	10.84%	149	25.65%	63	10.84%	405	32	7.90%	63	149	63	5	12	5
51013101400	1030	856	113	13.20%	183	21.38%	113	13.20%	686	33	4.81%	136	220	136	7	11	7
51013101500	451	451	18	3.99%	69	15.30%	18	3.99%	351	29	8.26%	18	69	18	1	6	1
51013101600	301	301	20	6.64%	38	12.62%	20	6.64%	242	48	19.83%	20	38	20	4	8	4
51013101700	382	382	20	5.24%	73	19.11%	20	5.24%	298	57	19.13%	20	73	20	4	14	4
51013101800	341	329	7	2.13%	61	18.54%	7	2.13%	237	42	17.72%	7	63	7	1	11	1
51013101900	170	170	28	16.47%	27	15.88%	28	16.47%	101	6	5.94%	28	27	28	2	2	2
51013102000	818	804	82	10.20%	190	23.63%	77	9.58%	708	270	38.14%	83	193	78	32	74	30
51013102100	542	417	67	16.07%	86	20.62%	62	14.87%	287	162	56.45%	87	112	81	49	63	45
51013102200	299	299	29	9.70%	61	20.40%	29	9.70%	209	40	19.14%	29	61	29	6	12	6
51013102300	466	466	24	5.15%	89	19.10%	24	5.15%	291	8	2.75%	24	89	24	1	2	1
51013102400	259	233	16	6.87%	39	16.74%	16	6.87%	182	28	15.38%	18	43	18	3	7	3
51013102500	322	322	20	6.21%	79	24.53%	20	6.21%	240	38	15.83%	20	79	20	3	13	3
51013102600	170	170	11	6.47%	43	25.29%	11	6.47%	145	22	15.17%	11	43	11	2	7	2
51013102700	126	126	0	0.00%	23	18.25%	0	0.00%	98	13	13.27%	0	23	0	0	3	0

May 2008

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Arlington County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51013102800	550	550	87	15.82%	123	22.36%	87	15.82%	354	59	16.67%	87	123	87	15	21	15
51013102900	131	131	0	0.00%	15	11.45%	0	0.00%	99	15	15.15%	0	15	0	0	2	0
51013103000	188	188	11	5.85%	11	5.85%	11	5.85%	153	5	3.27%	11	11	11	0	0	0
51013103100	488	488	78	15.98%	154	31.56%	71	14.55%	309	61	19.74%	78	154	71	15	30	14
51013103200	392	392	23	5.87%	57	14.54%	23	5.87%	295	39	13.22%	23	57	23	3	8	3
51013103300	197	197	73	37.06%	40	20.30%	73	37.06%	114	48	42.11%	73	40	73	31	17	31
51013103401	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51013103402	418	418	20	4.78%	54	12.92%	20	4.78%	307	15	4.89%	20	54	20	1	3	1
51013103500	1181	997	60	6.02%	164	16.45%	60	6.02%	824	325	39.44%	71	194	71	28	77	28
51013103600	299	299	0	0.00%	30	10.03%	0	0.00%	229	0	0.00%	0	30	0	0	0	0
51013103700	344	344	6	1.74%	25	7.27%	6	1.74%	208	0	0.00%	6	25	6	0	0	0
51013103800	185	185	16	8.65%	18	9.73%	16	8.65%	101	25	24.75%	16	18	16	4	4	4
TOTAL	**17215**	**16369**	**1381**		**2993**		**1356**		**11694**	**1862**		**1459**	**3147**	**1432**	**275**	**550**	**267**

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Alexandria City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51510200101	1179	697	69	9.90%	222	31.85%	69	9.90%	576	107	18.58%	117	376	117	22	70	22
51510200102	217	217	6	2.76%	28	12.90%	6	2.76%	129	7	5.43%	6	28	6	0	2	0
51510200103	317	317	21	6.62%	85	26.81%	21	6.62%	217	12	5.53%	21	85	21	1	5	1
51510200104	60	60	0	0.00%	33	55.00%	0	0.00%	33	4	12.12%	0	33	0	0	4	0
51510200105	270	270	47	17.41%	87	32.22%	47	17.41%	155	23	14.84%	47	87	47	7	13	7
51510200201	304	287	25	8.71%	38	13.24%	25	8.71%	203	41	20.20%	26	40	26	5	8	5
51510200202	285	279	15	5.38%	20	7.17%	15	5.38%	151	11	7.28%	15	20	15	1	1	1
51510200301	192	192	11	5.73%	27	14.06%	11	5.73%	124	9	7.26%	11	27	11	1	2	1
51510200302	432	432	47	10.88%	62	14.35%	47	10.88%	272	12	4.41%	47	62	47	2	3	2
51510200303	706	706	66	9.35%	194	27.48%	66	9.35%	594	359	60.44%	66	194	66	40	117	40
51510200401	212	212	11	5.19%	32	15.09%	6	2.83%	138	0	0.00%	11	32	6	0	0	0
51510200402	872	872	42	4.82%	184	21.10%	42	4.82%	648	62	9.57%	42	184	42	4	18	4
51510200500	368	368	28	7.61%	79	21.47%	28	7.61%	303	142	46.86%	28	79	28	13	37	13
51510200600	469	384	64	16.67%	79	20.57%	64	16.67%	233	11	4.72%	78	96	78	4	5	4
51510200700	402	402	50	12.44%	103	25.62%	50	12.44%	299	77	25.75%	50	103	50	13	27	13
51510200801	422	422	11	2.61%	56	13.27%	11	2.61%	283	9	3.18%	11	56	11	0	2	0
51510200802	193	193	11	5.70%	29	15.03%	11	5.70%	146	14	9.59%	11	29	11	1	3	1
51510200900	641	576	42	7.29%	92	15.97%	42	7.29%	391	19	4.86%	47	102	47	2	5	2
51510201000	222	222	13	5.86%	44	19.82%	13	5.86%	155	22	14.19%	13	44	13	2	6	2
51510201100	262	262	18	6.87%	18	6.87%	18	6.87%	159	0	0.00%	18	18	18	0	0	0
51510201202	170	170	29	17.06%	25	14.71%	29	17.06%	116	9	7.76%	29	25	29	2	2	2
51510201203	115	115	7	6.09%	35	30.43%	7	6.09%	38	6	15.79%	7	35	7	1	6	1
51510201204	193	193	14	7.25%	43	22.28%	14	7.25%	136	34	25.00%	14	43	14	4	11	4
51510201300	334	334	28	8.38%	49	14.67%	28	8.38%	241	72	29.88%	28	49	28	8	15	8
51510201400	266	266	16	6.02%	70	26.32%	16	6.02%	197	39	19.80%	16	70	16	3	14	3
51510201500	539	287	19	6.62%	36	12.54%	13	4.53%	197	31	15.74%	36	68	24	6	11	4
51510201600	291	291	15	5.15%	73	25.09%	15	5.15%	176	46	26.14%	15	73	15	4	19	4
51510201801	567	567	55	9.70%	84	14.81%	55	9.70%	495	231	46.67%	55	84	55	26	39	26

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Alexandria City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51510201802	188	188	0	0.00%	19	10.11%	0	0.00%	153	14	9.15%	0	19	0	0	2	0
51510201900	117	117	6	5.13%	6	5.13%	6	5.13%	88	12	13.64%	6	6	6	1	1	1
51510202001	313	313	6	1.92%	14	4.47%	6	1.92%	222	8	3.60%	6	14	6	0	1	0
51510202002	275	275	10	3.64%	18	6.55%	10	3.64%	227	24	10.57%	10	18	10	1	2	1
TOTAL	**11393**	**10486**	**802**		**1984**		**791**		**7495**	**1467**		**887**	**2200**	**871**	**174**	**447**	**173**

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Falls Church City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51610500100	321	321	29	9.03%	46	14.33%	29	9.03%	221	16	7.24%	29	46	29	2	3	2
51610500200	518	518	53	10.23%	96	18.53%	53	10.23%	366	74	20.22%	53	96	53	11	19	11
51610500300	439	370	13	3.51%	55	14.86%	6	1.62%	272	21	7.72%	15	65	7	1	5	1
TOTAL	**1278**	**1209**	**95**		**197**		**88**		**859**	**111**		**97**	**207**	**89**	**14**	**28**	**13**

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax City

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51600300100	534	534	39	7.30%	77	14.42%	39	7.30%	358	36	10.06%	39	77	39	4	8	4
51600300200	710	710	64	9.01%	132	18.59%	64	9.01%	467	6	1.28%	64	132	64	1	2	1
51600300300	495	495	14	2.83%	41	8.28%	14	2.83%	293	19	6.48%	14	41	14	1	3	1
51600300400	525	291	13	4.47%	60	20.62%	13	4.47%	174	22	12.64%	23	108	23	3	14	3
51600300500	451	356	27	7.58%	51	14.33%	27	7.58%	255	8	3.14%	34	65	34	1	2	1
TOTAL	**2715**	**2386**	**157**		**361**		**157**		**1547**	**91**		**175**	**423**	**175**	**10**	**28**	**10**

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059415100	465	465	33	7.10%	86	18.49%	33	7.10%	290	32	11.03%	33	86	33	4	9	4
51059415200	451	451	8	1.77%	36	7.98%	8	1.77%	342	57	16.67%	8	36	8	1	6	1
51059415300	532	532	107	20.11%	138	25.94%	107	20.11%	353	60	17.00%	107	138	107	18	23	18
51059415400	762	762	38	4.99%	41	5.38%	38	4.99%	492	22	4.47%	38	41	38	2	2	2
51059415500	998	844	38	4.50%	152	18.01%	31	3.67%	536	122	22.76%	45	180	37	10	41	8
51059415600	635	635	36	5.67%	42	6.61%	36	5.67%	446	36	8.07%	36	42	36	3	3	3
51059415700	679	679	33	4.86%	78	11.49%	33	4.86%	402	12	2.99%	33	78	33	1	2	1
51059415800	750	750	26	3.47%	46	6.13%	26	3.47%	465	0	0.00%	26	46	26	0	0	0
51059415900	589	589	25	4.24%	80	13.58%	25	4.24%	352	7	1.99%	25	80	25	0	2	0
51059416000	432	432	29	6.71%	51	11.81%	29	6.71%	248	28	11.29%	29	51	29	3	6	3
51059416100	672	672	85	12.65%	94	13.99%	85	12.65%	371	23	6.20%	85	94	85	5	6	5
51059416200	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059416300	214	214	40	18.69%	40	18.69%	40	18.69%	133	0	0.00%	40	40	40	0	0	0
51059420100	418	418	0	0.00%	25	5.98%	0	0.00%	258	8	3.10%	0	25	0	0	1	0
51059420200	440	436	49	11.24%	85	19.50%	49	11.24%	232	7	3.02%	49	86	49	1	3	1
51059420300	531	531	14	2.64%	61	11.49%	14	2.64%	373	20	5.36%	14	61	14	1	3	1
51059420400	151	151	19	12.58%	17	11.26%	19	12.58%	114	19	16.67%	19	17	19	3	3	3
51059420500	787	787	68	8.64%	86	10.93%	68	8.64%	555	35	6.31%	68	86	68	4	5	4
51059420600	281	281	12	4.27%	78	27.76%	12	4.27%	141	15	10.64%	12	78	12	1	8	1
51059420700	519	519	27	5.20%	68	13.10%	27	5.20%	323	16	4.95%	27	68	27	1	3	1
51059420800	510	510	18	3.53%	68	13.33%	18	3.53%	295	19	6.44%	18	68	18	1	4	1
51059421000	517	429	52	12.12%	77	17.95%	52	12.12%	296	21	7.09%	63	93	63	4	7	4
51059421100	437	437	16	3.66%	58	13.27%	16	3.66%	221	0	0.00%	16	58	16	0	0	0
51059421200	239	239	13	5.44%	37	15.48%	13	5.44%	135	5	3.70%	13	37	13	0	1	0
51059421300	192	192	16	8.33%	20	10.42%	16	8.33%	111	5	4.50%	16	20	16	1	1	1
51059421400	350	350	41	11.71%	83	23.71%	41	11.71%	226	70	30.97%	41	83	41	13	26	13
51059421500	392	392	29	7.40%	86	21.94%	29	7.40%	246	53	21.54%	29	86	29	6	19	6
51059421600	179	179	20	11.17%	25	13.97%	20	11.17%	102	25	24.51%	20	25	20	5	6	5

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059421700	543	541	22	4.07%	111	20.52%	22	4.07%	302	12	3.97%	22	111	22	1	4	1
51059421800	200	200	13	6.50%	37	18.50%	13	6.50%	136	28	20.59%	13	37	13	3	8	3
51059421900	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059422000	689	607	61	10.05%	97	15.98%	61	10.05%	428	17	3.97%	69	110	69	3	4	3
51059422100	292	237	14	5.91%	39	16.46%	14	5.91%	134	15	11.19%	17	48	17	2	5	2
51059422200	25	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059422300	376	376	31	8.24%	40	10.64%	31	8.24%	229	21	9.17%	31	40	31	3	4	3
51059422400	316	316	46	14.56%	111	35.13%	46	14.56%	200	19	9.50%	46	111	46	4	11	4
51059430100	504	504	33	6.55%	68	13.49%	33	6.55%	280	15	5.36%	33	68	33	2	4	2
51059430200	674	674	29	4.30%	125	18.55%	29	4.30%	344	8	2.33%	29	125	29	1	3	1
51059430400	807	807	46	5.70%	97	12.02%	46	5.70%	477	14	2.94%	46	97	46	1	3	1
51059430500	190	190	0	0.00%	0	0.00%	0	0.00%	112	0	0.00%	0	0	0	0	0	0
51059430600	515	515	39	7.57%	126	24.47%	39	7.57%	317	42	13.25%	39	126	39	5	17	5
51059430700	339	339	53	15.63%	76	22.42%	53	15.63%	248	38	15.32%	53	76	53	8	12	8
51059430800	977	977	59	6.04%	117	11.98%	59	6.04%	597	25	4.19%	59	117	59	2	5	2
51059430900	328	328	38	11.59%	73	22.26%	38	11.59%	159	0	0.00%	38	73	38	0	0	0
51059431000	339	339	27	7.96%	52	15.34%	27	7.96%	155	13	8.39%	27	52	27	2	4	2
51059431300	330	330	7	2.12%	43	13.03%	7	2.12%	177	9	5.08%	7	43	7	0	2	0
51059431400	342	342	18	5.26%	36	10.53%	18	5.26%	199	7	3.52%	18	36	18	1	1	1
51059431500	528	528	25	4.73%	51	9.66%	25	4.73%	320	5	1.56%	25	51	25	0	1	0
51059431600	849	849	31	3.65%	148	17.43%	31	3.65%	539	26	4.82%	31	148	31	1	7	1
51059431800	371	371	36	9.70%	50	13.48%	36	9.70%	204	15	7.35%	36	50	36	3	4	3
51059431900	186	186	5	2.69%	26	13.98%	5	2.69%	89	6	6.74%	5	26	5	0	2	0
51059432000	106	106	7	6.60%	25	23.58%	7	6.60%	53	5	9.43%	7	25	7	1	2	1
51059432100	222	222	21	9.46%	30	13.51%	21	9.46%	154	21	13.64%	21	30	21	3	4	3
51059432200	592	356	34	9.55%	98	27.53%	34	9.55%	235	63	26.81%	57	163	57	15	44	15
51059432300	324	324	35	10.80%	65	20.06%	35	10.80%	174	70	40.23%	35	65	35	14	26	14
51059432400	331	331	31	9.37%	92	27.79%	31	9.37%	153	8	5.23%	31	92	31	2	5	2
51059432500	180	180	15	8.33%	44	24.44%	15	8.33%	91	0	0.00%	15	44	15	0	0	0

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059432600	92	92	14	15.22%	20	21.74%	14	15.22%	43	5	11.63%	14	20	14	2	2	2
51059432700	344	344	23	6.69%	73	21.22%	23	6.69%	176	0	0.00%	23	73	23	0	0	0
51059432800	101	101	4	3.96%	12	11.88%	4	3.96%	48	10	20.83%	4	12	4	1	3	1
51059440100	1488	1142	71	6.22%	242	21.19%	71	6.22%	813	52	6.40%	93	315	93	6	20	6
51059440200	368	368	20	5.43%	54	14.67%	20	5.43%	259	48	18.53%	20	54	20	4	10	4
51059440300	375	375	19	5.07%	34	9.07%	19	5.07%	227	12	5.29%	19	34	19	1	2	1
51059440500	672	672	24	3.57%	69	10.27%	24	3.57%	373	7	1.88%	24	69	24	0	1	0
51059440600	225	225	19	8.44%	26	11.56%	19	8.44%	149	19	12.75%	19	26	19	2	3	2
51059440700	1031	1031	64	6.21%	104	10.09%	64	6.21%	635	30	4.72%	64	104	64	3	5	3
51059440800	1012	1012	63	6.23%	174	17.19%	63	6.23%	636	72	11.32%	63	174	63	7	20	7
51059450100	281	281	22	7.83%	29	10.32%	22	7.83%	183	24	13.11%	22	29	22	3	4	3
51059450200	371	371	36	9.70%	91	24.53%	36	9.70%	236	51	21.61%	36	91	36	8	20	8
51059450300	451	451	11	2.44%	39	8.65%	11	2.44%	326	63	19.33%	11	39	11	2	8	2
51059450400	380	380	25	6.58%	74	19.47%	25	6.58%	235	20	8.51%	25	74	25	2	6	2
51059450500	219	219	30	13.70%	46	21.00%	30	13.70%	138	19	13.77%	30	46	30	4	6	4
51059450600	787	787	85	10.80%	144	18.30%	85	10.80%	515	41	7.96%	85	144	85	7	11	7
51059450700	540	540	70	12.96%	130	24.07%	70	12.96%	270	17	6.30%	70	130	70	4	8	4
51059450800	511	511	5	0.98%	55	10.76%	5	0.98%	332	48	14.46%	5	55	5	1	8	1
51059450900	221	221	10	4.52%	31	14.03%	10	4.52%	151	27	17.88%	10	31	10	2	6	2
51059451000	596	397	28	7.05%	45	11.34%	28	7.05%	234	4	1.71%	42	68	42	1	1	1
51059451100	395	395	39	9.87%	59	14.94%	39	9.87%	253	0	0.00%	39	59	39	0	0	0
51059451200	338	338	12	3.55%	31	9.17%	12	3.55%	224	0	0.00%	12	31	12	0	0	0
51059451300	310	310	21	6.77%	67	21.61%	21	6.77%	226	0	0.00%	21	67	21	0	0	0
51059451400	173	173	3	1.73%	8	4.62%	3	1.73%	98	35	35.71%	3	8	3	1	3	1
51059451500	1133	1075	100	9.30%	205	19.07%	100	9.30%	709	138	19.46%	105	216	105	21	42	21
51059451600	424	424	31	7.31%	109	25.71%	18	4.25%	280	17	6.07%	31	109	18	2	7	1
51059451800	425	425	32	7.53%	70	16.47%	32	7.53%	293	6	2.05%	32	70	32	1	1	1
51059451900	481	434	29	6.68%	56	12.90%	29	6.68%	252	38	15.08%	32	62	32	5	9	5
51059452000	528	528	62	11.74%	125	23.67%	62	11.74%	408	183	44.85%	62	125	62	28	56	28

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059452100	959	821	10	1.22%	151	18.39%	10	1.22%	513	75	14.62%	12	176	12	2	26	2
51059452200	619	619	39	6.30%	51	8.24%	39	6.30%	320	19	5.94%	39	51	39	2	3	2
51059452300	458	458	75	16.38%	106	23.14%	66	14.41%	280	36	12.86%	75	106	66	10	14	8
51059452400	710	710	149	20.99%	185	26.06%	149	20.99%	389	28	7.20%	149	185	149	11	13	11
51059452500	787	734	45	6.13%	121	16.49%	45	6.13%	382	52	13.61%	48	130	48	7	18	7
51059452600	324	324	31	9.57%	30	9.26%	31	9.57%	218	43	19.72%	31	30	31	6	6	6
51059452700	279	279	15	5.38%	55	19.71%	15	5.38%	182	55	30.22%	15	55	15	5	17	5
51059452800	1244	1244	85	6.83%	171	13.75%	85	6.83%	893	70	7.84%	85	171	85	7	13	7
51059460100	346	346	13	3.76%	23	6.65%	13	3.76%	205	9	4.39%	13	23	13	1	1	1
51059460200	370	370	25	6.76%	44	11.89%	25	6.76%	197	0	0.00%	25	44	25	0	0	0
51059460300	289	289	6	2.08%	30	10.38%	6	2.08%	174	7	4.02%	6	30	6	0	1	0
51059460400	750	750	48	6.40%	147	19.60%	48	6.40%	526	235	44.68%	48	147	48	21	66	21
51059460500	414	414	20	4.83%	57	13.77%	20	4.83%	216	23	10.65%	20	57	20	2	6	2
51059460600	616	557	54	9.69%	57	10.23%	54	9.69%	350	14	4.00%	60	63	60	2	3	2
51059460700	904	904	39	4.31%	120	13.27%	39	4.31%	583	15	2.57%	39	120	39	1	3	1
51059460800	356	213	19	8.92%	46	21.60%	19	8.92%	248	10	4.03%	32	77	32	1	3	1
51059460900	300	135	12	8.89%	35	25.93%	12	8.89%	183	5	2.73%	27	78	27	1	2	1
51059461000	272	155	17	10.97%	80	51.61%	17	10.97%	180	35	19.44%	30	140	30	6	27	6
51059461100	839	410	24	5.85%	111	27.07%	24	5.85%	440	16	3.64%	49	227	49	2	8	2
51059461200	451	219	13	5.94%	27	12.33%	13	5.94%	266	16	6.02%	27	56	27	2	3	2
51059461500	317	181	62	34.25%	65	35.91%	62	34.25%	151	17	11.26%	109	114	109	12	13	12
51059461600	408	224	39	17.41%	51	22.77%	39	17.41%	250	8	3.20%	71	93	71	2	3	2
51059461700	376	193	36	18.65%	43	22.28%	36	18.65%	238	6	2.52%	70	84	70	2	2	2
51059461800	310	191	9	4.71%	30	15.71%	9	4.71%	217	24	11.06%	15	49	15	2	5	2
51059461900	336	187	38	20.32%	75	40.11%	38	20.32%	168	43	25.60%	68	135	68	17	34	17
51059470100	340	161	40	24.84%	73	45.34%	40	24.84%	205	12	5.85%	84	154	84	5	9	5
51059470200	0	0	0	0.00%	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0	0
51059470300	527	253	29	11.46%	85	33.60%	22	8.70%	322	6	1.86%	60	177	46	1	3	1
51059470400	731	396	29	7.32%	64	16.16%	29	7.32%	432	18	4.17%	54	118	54	2	5	2

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059470500	822	468	39	8.33%	87	18.59%	39	8.33%	545	49	8.99%	69	153	69	6	14	6
51059470600	458	307	62	20.20%	100	32.57%	56	18.24%	322	56	17.39%	92	149	84	16	26	15
51059470700	773	430	11	2.56%	66	15.35%	11	2.56%	512	7	1.37%	20	119	20	0	2	0
51059470800	450	243	39	16.05%	31	12.76%	39	16.05%	290	23	7.93%	72	57	72	6	5	6
51059470900	1068	514	65	12.65%	118	22.96%	65	12.65%	631	70	11.09%	135	245	135	15	27	15
51059471000	226	128	16	12.50%	36	28.13%	16	12.50%	157	0	0.00%	28	64	28	0	0	0
51059471100	736	396	28	7.07%	99	25.00%	28	7.07%	454	48	10.57%	52	184	52	6	19	6
51059471200	554	331	31	9.37%	39	11.78%	31	9.37%	415	48	11.57%	52	65	52	6	8	6
51059471300	651	365	93	25.48%	145	39.73%	93	25.48%	360	37	10.28%	166	259	166	17	27	17
51059471400	510	307	44	14.33%	84	27.36%	44	14.33%	323	16	4.95%	73	140	73	4	7	4
51059480100	349	181	25	13.81%	24	13.26%	25	13.81%	235	24	10.21%	48	46	48	5	5	5
51059480200	1145	657	48	7.31%	114	17.35%	48	7.31%	736	51	6.93%	84	199	84	6	14	6
51059480300	659	312	57	18.27%	48	15.38%	57	18.27%	434	9	2.07%	120	101	120	2	2	2
51059480400	619	296	42	14.19%	75	25.34%	42	14.19%	361	19	5.26%	88	157	88	5	8	5
51059480500	383	192	30	15.63%	108	56.25%	30	15.63%	189	29	15.34%	60	215	60	9	33	9
51059480800	327	206	9	4.37%	57	27.67%	9	4.37%	180	32	17.78%	14	90	14	3	16	3
51059480900	508	294	70	23.81%	104	35.37%	70	23.81%	286	65	22.73%	121	180	121	27	41	27
51059481000	132	73	0	0.00%	5	6.85%	0	0.00%	63	0	0.00%	0	9	0	0	0	0
51059481100	402	246	34	13.82%	72	29.27%	34	13.82%	209	18	8.61%	56	118	56	5	10	5
51059481200	259	140	9	6.43%	46	32.86%	9	6.43%	124	30	24.19%	17	85	17	4	21	4
51059481400	689	432	60	13.89%	152	35.19%	60	13.89%	459	191	41.61%	96	242	96	40	101	40
51059481500	162	74	12	16.22%	37	50.00%	12	16.22%	102	0	0.00%	26	81	26	0	0	0
51059481600	233	89	13	14.61%	21	23.60%	13	14.61%	142	3	2.11%	34	55	34	1	1	1
51059481700	419	224	25	11.16%	57	25.45%	25	11.16%	260	21	8.08%	47	107	47	4	9	4
51059481900	472	222	91	40.99%	102	45.95%	91	40.99%	229	65	28.38%	193	217	193	55	62	55
51059482000	428	228	8	3.51%	55	24.12%	8	3.51%	343	43	12.54%	15	103	15	2	13	2
51059482100	283	144	15	10.42%	41	28.47%	15	10.42%	227	20	8.81%	29	81	29	3	7	3
51059482200	872	455	76	16.70%	142	31.21%	76	16.70%	480	132	27.50%	146	272	146	40	75	40
51059482300	731	420	26	6.19%	82	19.52%	26	6.19%	487	22	4.52%	45	143	45	2	6	2

Aggressive Demographic Market Assessment at 165% FPL by Census Tract for Fairfax County

Census Tract	Age 65+, All	Age 65+, Non-institution-alized	Clinical Eligibility Estimate						Income Eligibility Estimate			Estimated Clinically Eligible Population			Estimated Clinically and Financially Eligible Population		
			Self-Care	%	Go-Outside Home	%	2+ADLs (incl. Self-Care)	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)	Self-Care	Go-Outside Home	2+ADLs (incl. Self-Care)
51059482400	188	112	4	3.57%	6	5.36%	4	3.57%	109	14	12.84%	7	10	7	1	1	1
51059482500	290	161	13	8.07%	83	51.55%	13	8.07%	133	0	0.00%	23	150	23	0	0	0
51059482600	397	220	0	0.00%	82	37.27%	0	0.00%	249	47	18.88%	0	148	0	0	28	0
51059490100	505	356	70	19.66%	151	42.42%	70	19.66%	300	89	29.67%	99	214	99	29	64	29
51059490500	419	241	23	9.54%	61	25.31%	23	9.54%	234	16	6.84%	40	106	40	3	7	3
51059490900	1	1	0	0.00%	0	0.00%	0	0.00%	1	0	0.00%	0	0	0	0	0	0
51059491000	145	70	11	15.71%	30	42.86%	11	15.71%	69	8	11.59%	23	62	23	3	7	3
51059491100	452	226	11	4.87%	78	34.51%	11	4.87%	182	10	5.49%	22	156	22	1	9	1
51059491200	126	67	7	10.45%	7	10.45%	7	10.45%	55	8	14.55%	13	13	13	2	2	2
51059491300	298	173	25	14.45%	37	21.39%	25	14.45%	140	25	17.86%	43	64	43	8	11	8
51059491400	340	202	27	13.37%	85	42.08%	27	13.37%	128	0	0.00%	45	143	45	0	0	0
51059491500	290	166	54	32.53%	73	43.98%	54	32.53%	161	17	10.56%	94	128	94	10	13	10
51059491600	323	184	43	23.37%	102	55.43%	22	11.96%	195	48	24.62%	75	179	39	19	44	10
51059491700	559	286	38	13.29%	89	31.12%	38	13.29%	237	41	17.30%	74	174	74	13	30	13
51059491800	688	389	67	17.22%	82	21.08%	67	17.22%	429	41	9.56%	118	145	118	11	14	11
51059491900	288	153	33	21.57%	67	43.79%	33	21.57%	148	18	12.16%	62	126	62	8	15	8
51059492000	618	287	92	32.06%	117	40.77%	92	32.06%	328	24	7.32%	198	252	198	14	18	14
51059492100	473	212	25	11.79%	45	21.23%	25	11.79%	268	6	2.24%	56	100	56	1	2	1
51059492200	676	335	69	20.60%	142	42.39%	69	20.60%	278	0	0.00%	139	287	139	0	0	0
51059492300	38	31	0	0.00%	0	0.00%	0	0.00%	15	0	0.00%	0	0	0	0	0	0
51059492400	63	31	8	25.81%	32	103.23%	8	25.81%	31	0	0.00%	16	65	16	0	0	0
TOTAL	**75998**	**61587**	**5359**		**11506**		**5296**		**45259**	**4642**		**7244**	**15448**	**7154**	**825**	**1765**	**811**

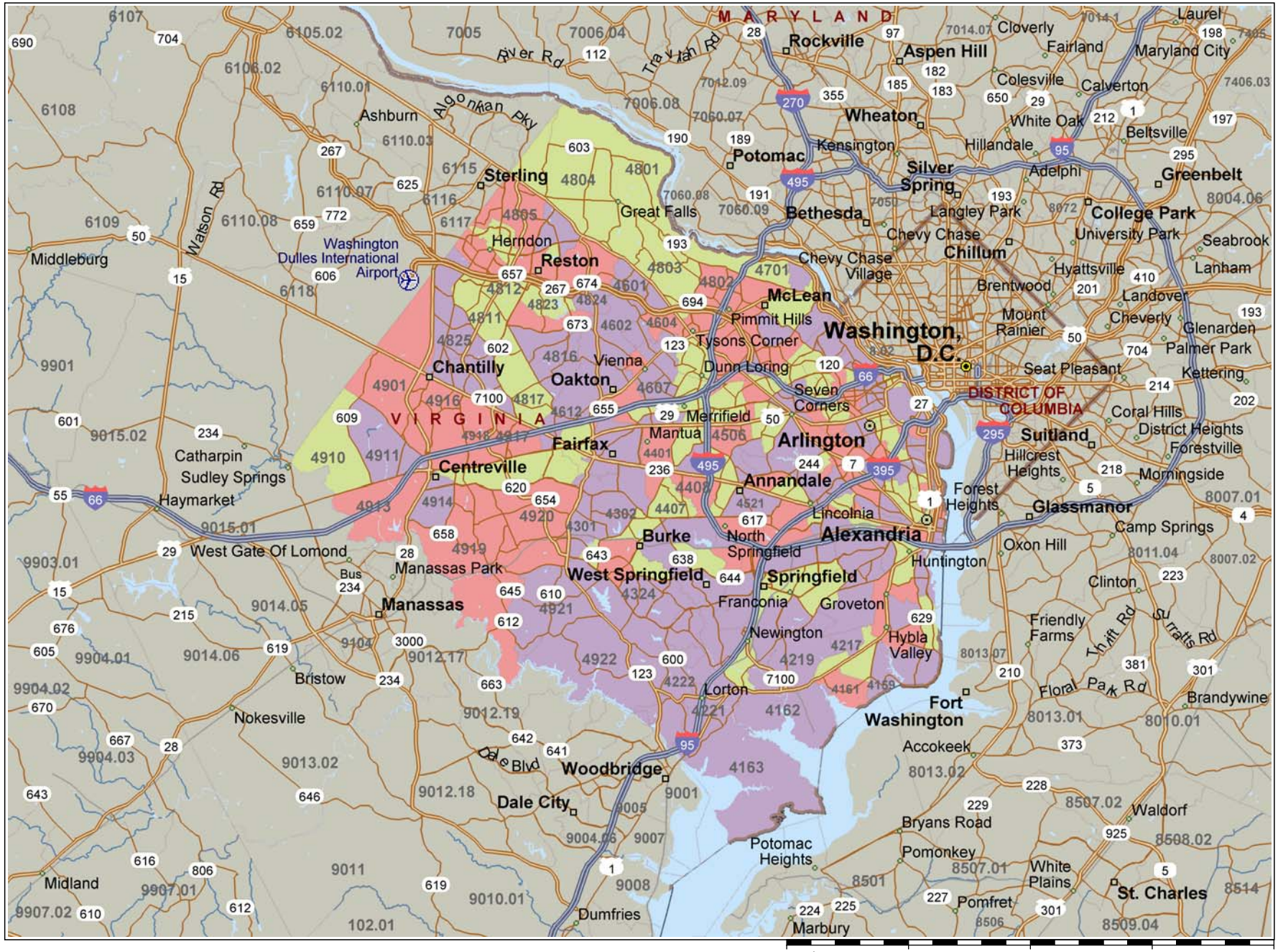
Appendix E

PACE Eligible Demographic Market Assessment Map for Fairfax

Northern VA Demographic Market Assessment Map at 165% FPL

Number by Census Tract

- 5 to 55
- 2 to 4
- 0.00 to 1



Appendix F

Fairfax Financial Proforma

Census, Utilization, and Capital Costs Assumptions

Fairfax PACE PACE Proforma & Five Year Projecton	Cost Basis	Start Up Period	Monthly Expense	Year 1 Dec-10	Year 2 Dec-11	Year 3 Dec-12	Year 4 Dec-13	Year 5 Dec-14
Capitation Revenue PMM				$6,250	$6,428	$6,585	$6,767	$6,954
Medical Cost PMM				6,358	4,531	4,419	4,666	4,819
Total Program Services Income/(Loss)				(108)	1,896	2,166	2,101	2,136
Other Operating Revenue PMM				-	-	-	-	-
General & Admininstrative PMM				5,688	1,864	1,379	1,425	1,467
Depreciation PMM				278	90	67	60	61
Interest Cost PMM				495	230	176	150	124
Total Cost PMM				12,819	6,716	6,041	6,301	6,471
Non-Operating Revenue PMM				-	-	-	-	-
Income/(Loss) PMM				$ (6,570)	$ (288)	$ 543	$ 466	$ 483
Reserves & Investments-Ending				494,866	1,078,955	1,203,424	1,269,309	1,264,351
Required Reserve Calculation				$ 471,064	$ 1,064,234	$ 1,176,030	$ 1,224,828	$ 1,261,992
(Deficiency)/Excess				$ 23,803	$ 14,721	$ 27,394	$ 44,481	$ 2,359
				-	(0)	(0)	(0)	-
CENSUS/ATTENDANCE								
Beginning Enrollment Census				4				
Census - Average Net Enrollment Growth	**Input on Detail Tables Tab**			4.6	5.4	0.0	0.0	0.0
Year End Enrollment				59	124	124	124	124
Average Enrollment				27	87	124	124	124
Member Months				323	1,048	1,488	1,488	1,488
PACE Center Days Open Per Week				5	5	5	5	5
Average Daily Attendance (Per Member Per Week)				3.00	3.00	3.00	3.00	3.00
PACE Center Attendance Capacity				90	90	170	170	170
Average Daily Attendance				16	52	74	74	74
PACE Center Census Capacity				150	150	283	283	283
Pre-PACE				N	N	N	N	N
Payor Mix								
Medicare A & B/Medicaid				90.0%	90.0%	90.0%	90.0%	90.0%
Medicare A Only/Medicaid				0.0%	0.0%	0.0%	0.0%	0.0%
Medicare B Only/Medicaid				0.0%	0.0%	0.0%	0.0%	0.0%
Medicare ESRD/Medicaid				2.0%	2.0%	2.0%	2.0%	2.0%
Medicare A & B/Medicaid Private				0.0%	0.0%	0.0%	0.0%	0.0%
Medicaid Only				4.0%	4.0%	4.0%	4.0%	4.0%
Private Pay				4.0%	4.0%	4.0%	4.0%	4.0%
				0.0%	0.0%	0.0%	0.0%	0.0%
				0.0%	0.0%	0.0%	0.0%	0.0%
Total				100.0%	100.0%	100.0%	100.0%	100.0%
CAPITATION RATES/INFLATION FACTORS	Base Year Rate			Capitation Rate Inflation Factors				
Medicare A & B	$ 1,918.94			$ 1,918.94	$ 1,919.90	$ 1,918.58	$ 1,914.81	$ 1,908.42
	Inflation			3.5%	3.5%	3.5%	3.5%	3.5%
Medicare A Only	$ 999.96			$ 999.96	$ 1,000.46	$ 999.77	$ 997.81	$ 994.48
	Inflation			3.5%	3.5%	3.5%	3.5%	3.5%
Medicare B Only	$ 918.98			$ 918.98	$ 919.44	$ 918.81	$ 917.00	$ 913.94
				3.5%	3.5%	3.5%	3.5%	3.5%
Medicare ESRD	$ 8,359.31			$ 8,359.31	$ 8,651.88	$ 8,954.70	$ 9,268.11	$ 9,592.50
	Inflation			3.5%	4.0%	4.0%	4.0%	4.0%
Medicare D	$ 524.12			$ 524.12	$ 539.84	$ 556.04	$ 572.72	$ 589.90
	Inflation			3.0%	3.0%	3.0%	3.0%	3.0%
Medicaid Only (Non Dual Eligibles)/Base Year FY 2008	$4,443.52			$ 4,443.52	$ 4,576.83	$ 4,714.13	$ 4,855.55	$ 5,001.22
	Inflation			0.0%	3.0%	3.0%	3.0%	3.0%
Medicaid (Dual Eligibles)/Base Year FY 2008	$3,533.48			$ 3,816.16	$ 3,968.81	$ 4,127.56	$ 4,292.66	$ 4,464.37
	Inflation			8.0%	4.0%	4.0%	4.0%	4.0%
Private Pay/Base Year FY 2008	$3,533.48			$ 3,816.16	$ 3,968.81	$ 4,127.56	$ 4,292.66	$ 4,464.37
	Inflation			8.0%	4.0%	4.0%	4.0%	4.0%
				$ -	$ -	$ -	$ -	$ -
	Inflation							
				$ -	$ -	$ -	$ -	$ -
	Inflation							
Other Revenue PMPM	$0.00			$ -	$ -	$ -	$ -	$ -
	Inflation			0.0%	0.0%	0.0%	0.0%	0.0%
Other Revenue - Annual Amount	$0			$ -	$ -	$ -	$ -	$ -
	Inflation			0.0%	0.0%	0.0%	0.0%	0.0%
Other Revenue - Annual Amount	$0			$ -	$ -	$ -	$ -	$ -
				0.0%	0.0%	0.0%	0.0%	0.0%

Medicare Rate Calculation (Blended)

ESRD	$ 8,359.31	$ 8,651.88	$ 8,954.70	$ 9,268.11	$ 9,592.50
Part A & B	$ 1,918.94	$ 1,919.90	$ 1,918.58	$ 1,914.81	$ 1,908.42
Part A Only	$ 999.96	$ 1,000.46	$ 999.77	$ 997.81	$ 994.48
Part B Only	$ 918.98	$ 919.44	$ 918.81	$ 917.00	$ 913.94
Part D	$ 524.12	$ 539.84	$ 556.04	$ 572.72	$ 589.90

		Base Period	2009	Dec-10	Dec-11	Dec-12	Dec-13	Dec-14
County Name>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	Fairfax County**	ESRD Part A	$ 2,210.46	$ 3,340.23	$ 3,457.13	$ 3,578.13	$ 3,703.37	$ 3,832.99
	100%	ESRD Part B	$ 3,565.70	$ 5,019.08	$ 5,194.75	$ 5,376.56	$ 5,564.74	$ 5,759.51
		Part A Aged	$ 402.56	416.65	431.23	446.33	461.95	478.11
		Part B Aged	$ 369.96	382.91	396.31	410.18	424.54	439.40
		Phase In Year		2008+	2008+	2008+	2008+	2008+
		Rescaling Factor		100%	100%	100%	100%	100%
		Risk Adjustment Score		2.40	2.32	2.24	2.16	2.08
		Rescaling Factor		1.0000	1.0000	1.0000	1.0000	1.0000
				2.39	2.39	2.39	2.39	2.39
		Risk Adjusted Rate		$ 1,918.94	$ 1,919.90	$ 1,918.58	$ 1,914.81	$ 1,908.42
		Risk Adjusted Rate Part A		$ 999.96	$ 1,000.46	$ 999.77	$ 997.81	$ 994.48
		Risk Adjusted Rate Part B		$ 918.98	$ 919.44	$ 918.81	$ 917.00	$ 913.94
	Part D	Risk Adjustment Score		1.10	1.10	1.10	1.10	1.10
		Revenue/Expense Ratio		105.9%	105.9%	105.9%	105.9%	105.9%
		Pharmacy Costs		425.00	437.75	450.88	464.41	478.34
		Part D		450.00	463.50	477.41	491.73	506.48
				$ 524.12	$ 539.84	$ 556.04	$ 572.72	$ 589.90
County Name>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	Alexandria	ESRD Part A		$ -	$ -	$ -	$ -	$ -
		ESRD Part B		$ -	$ -	$ -	$ -	$ -
		Part A Aged		-	-	-	-	-
		Part B Aged		-	-	-	-	-
		Rescaling Factor		100%	100%	100%	100%	100%
		Risk Adjustment Score						
		Rescaling Factor		1.0000	1.0000	1.0000	1.0000	1.0000
				2.39	2.39	2.39	2.39	2.39
		Risk Adjusted Rate		$ -	$ -	$ -	$ -	$ -
		Risk Adjusted Rate Part A		$ -	$ -	$ -	$ -	$ -
		Risk Adjusted Rate Part B		$ -	$ -	$ -	$ -	$ -
	Part D	Risk Adjustment Score		1.10	1.10	1.10	1.10	1.10
				1.0588	1.0588	1.0588	1.0588	1.0588
		Part D		450.00	463.50	477.41	491.73	506.48
				$ 524.12	$ 539.84	$ 556.04	$ 572.72	$ 589.90
County Name>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>		ESRD Part A		$ -	$ -	$ -	$ -	$ -
		ESRD Part B		$ -	$ -	$ -	$ -	$ -
		Part A Aged		-	-	-	-	-
		Part B Aged		-	-	-	-	-
				100%	100%	100%	100%	100%
		Risk Adjustment Score		-	-	-	-	-
		Rescaling Facor		1.0000	1.0000	1.0000	1.0000	1.0000
				2.39	2.39	2.39	2.39	2.39
		Risk Adjusted Rate		$ -	$ -	$ -	$ -	$ -
		Risk Adjusted Rate Part A		$ -	$ -	$ -	$ -	$ -
		Risk Adjusted Rate Part B		$ -	$ -	$ -	$ -	$ -
	Part D	Risk Adjustment Score		1.10	1.10	1.10	1.10	1.10
		Rescaling Factor		1.0588	1.0588	1.0588	1.0588	1.0588
		Part D		450.00	463.50	477.41	491.73	506.48
				$ 524.12	$ 539.84	$ 556.04	$ 572.72	$ 589.90
	100%							

Fairfax PACE
PACE Proforma & Five Year Projecton
Operating Expense Assumption

	Cost Basis			Year 1	Year 2	Year 3	Year 4	Year 5
	Member Months	Start Up Period	Monthly Start Up Costs	323	1,048	1,488	1,488	1,488
	Inflation			3.0%	3.0%	3.0%	3.0%	3.0%
Transportation	**Enrollee's Per F.T.E.**			**26.9**	**87.3**	**124.0**	**124.0**	**124.0**
Total Cost Per Member Month				$ 773.24	$ 690.10	$ 696.37	$ 717.26	$ 738.78
Purchased Service	Days			$40.00	$41.20	$42.44	$43.71	$45.02
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Other Trips), Miscellaneous	Days	-	$ -	$8.00	$8.24	$8.49	$8.74	$9.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Nursing	**Enrollee's Per F.T.E.**			**25.6**	**44.4**	**49.6**	**49.6**	**49.6**
Total Cost Per Member Month				$ 324.10	$ 193.56	$ 178.73	$ 184.08	$ 189.60
Purchased Service	PMM	-	$ -	$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Med/Surg Supplies, OTC Meds)	PMM	-	$ -	$2.00	$2.06	$2.12	$2.19	$2.25
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Nutrition	**Enrollee's Per F.T.E.**			**53.8**	**174.7**	**248.0**	**248.0**	**248.0**
Total Cost Per Member Month				$ 199.65	$ 111.12	$ 101.63	$ 104.68	$ 107.82
Purchased Service	PMM			$55.00	$56.65	$58.35	$60.10	$61.90
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Food, Supplements, Misc Other)	PMM	17	$ 1,000	$12.00	$12.36	$12.73	$13.11	$13.51
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Social Services	**Enrollee's Per F.T.E.**			**23.4**	**35.5**	**40.0**	**40.0**	**40.0**
Total Cost Per Member Month				$ 289.54	$ 197.73	$ 181.27	$ 186.69	$ 192.27
Purchased Service	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Travel, Conferences, Misc Other)	PMM	17	$ 500	$3.50	$3.61	$3.71	$3.82	$3.94
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Recreational Therapy	**Enrollee's Per F.T.E.**			**26.9**	**87.3**	**124.0**	**124.0**	**124.0**
Total Cost Per Member Month				$ 209.27	$ 67.85	$ 49.86	$ 51.35	$ 52.89
Purchased Service	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Misc Other)	PMM	17	$ 600	$2.00	$2.06	$2.12	$2.19	$2.25
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Restorative Therapy	**Enrollee's Per F.T.E.**			**31.7**	**56.3**	**67.0**	**67.0**	**67.0**
Total Cost Per Member Month				$ 264.34	$ 155.27	$ 135.28	$ 139.34	$ 143.51
Purchased Service	PMM	-	$ -	$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Equipment, Misc Other)	PMM	-	$ -	$5.00	$5.15	$5.30	$5.46	$5.63
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Center Support	**Enrollee's Per F.T.E.**			**6.8**	**11.6**	**13.2**	**13.2**	**13.2**
Total Cost Per Member Month				$ 840.90	$ 445.59	$ 392.56	$ 404.28	$ 416.42
Purchased Service	PMM	-	$ -	$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Travel, Equipment, Misc Other)	PMM	-	$ -	$40.00	$41.20	$42.44	$43.71	$45.02
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
In-Home Services	**Enrollee's Per F.T.E.**			**25.6**	**44.4**	**49.6**	**49.6**	**49.6**
Total Cost Per Member Month				$ 728.36	$ 636.52	$ 638.84	$ 657.99	$ 677.72
Purchased Service - Skilled Care	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Cost Per Visit			$ 72.00	$ 74.16	$ 76.38	$ 78.68	$ 81.04
	# of Visits PMM			2.00	2.00	2.00	2.00	2.00
	% of Participants			5.0%	5.0%	5.0%	5.0%	5.0%
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Other (Aides, Sitters, Misc Other)	PMM			$400.00	$412.00	$424.36	$437.09	$450.20
	Cost Per Visit				$ -	$ -	$ -	$ -
	# of Visits PMM							
	% of Participants			100.0%	100.0%	100.0%	100.0%	100.0%
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense - DME	PMM			$30.00	$30.90	$31.83	$32.78	$33.77
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Travel, Misc Other)	PMM	-		$30.00	$30.90	$31.83	$32.78	$33.77
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%

Fairfax PACE
PACE Proforma & Five Year Projecton
Operating Expense Assumption

	Cost Basis			Year 1	Year 2	Year 3	Year 4	Year 5
	Member Months	Start Up Period	Monthly Start Up Costs	323	1,048	1,488	1,488	1,488
	Inflation			3.0%	3.0%	3.0%	3.0%	3.0%
Pharmacy	**Enrollee's Per F.T.E.**			**107.7**	**349.3**	**496.0**	**496.0**	**496.0**
Total Cost Per Member Month				$ 552.91	$ 511.77	$ 520.53	$ 537.65	$ 555.38
Purchased Service - Dispensing	PMM	-		$45.00	$47.69	$50.55	$53.58	$56.78
	Experience Adjustment				2.9%	2.9%	2.9%	2.9%
Covered Part D Drugs	PMM	-	$ -	$425.00	$437.75	$450.88	$464.41	$478.34
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Non-Covered Part D Drugs	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Cost Per Prescription				$ -	$ -	$ -	$ -	$ -
# of Prescriptions Per Participant				0.0				
Other Expense	PMM	-	$ -		$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Primary Care	**Enrollee's Per F.T.E.**			**21.5**	**61.8**	**77.5**	**77.5**	**77.5**
Total Cost Per Member Month				$ 1,134.12	$ 378.79	$ 292.67	$ 301.45	$ 310.50
Purchased Service	Monthly	-	$ -		$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
On Call Expense	Monthly	-	$ -	$11,000.00	$11,330.00	$11,669.90	$12,020.00	$12,380.60
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%

Fairfax PACE
PACE Proforma & Five Year Projecton
Operating Expense Assumption

	Cost Basis	Start Up Month	Monthly Start Up Costs	Year 1	Year 2	Year 3	Year 4	Year 5
	Member Months			323	1,048	1,488	1,488	1,488
	Inflation			3.0%	3.0%	3.0%	3.0%	3.0%
Routine Specialists								
Total Cost Per Member Month				$ 22.00	$ 22.66	$ 23.34	$ 24.04	$ 24.76
Purchased Service (Audiology, Dentist, Optometrist, Podiatry, Psychiatr	PMM			$22.00	$22.66	$23.34	$24.04	$24.76
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Outpatient Services								
Total Cost Per Member Month				$ 261.46	$ 213.47	$ 208.97	$ 213.75	$ 218.67
Purchased Service - Radiology	PMM			$25.00	$25.75	$26.52	$27.32	$28.14
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Laboratory	PMM			$35.00	$36.05	$37.13	$38.25	$39.39
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Dialysis	Monthly	Baseline	$3,000	$3,000.00	$5,150.00	$6,180.00	$6,180.00	$6,180.00
			Rev PMM	$ 8,359	$ 8,652	$ 8,955	$ 9,268	$ 9,592
			Cost PMM	$ 6,000	$ 3,090	$ 3,090	$ 3,090	$ 3,090
			Margin	**$ 2,359**	**$ 5,562**	**$ 5,865**	**$ 6,178**	**$ 6,502**
			Member Mo.	6	20	24	24	24
			Cost Basis	$3,000	$3,090	$3,183	$3,278	$3,377
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - O/P Surgery	PMM			$90.00	$92.70	$95.48	$98.35	$101.30
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Other (End of Life, Other)	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Inpatient Services								
Total Cost Per Member Month				$ 758.16	$ 906.83	$ 998.84	$ 1,143.19	$ 1,190.19
Purchased Service - Acute Hospital	Days/1000			3,400	3,200	3,000	2,700	2,400
	Days			92	279	372	335	298
	Daily Rate			$2,000.00	$2,060.00	$2,121.80	$2,185.45	$2,251.02
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - I/P Specialist Cost	PMM			$15.00	$15.45	$15.91	$16.39	$16.88
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Ambulance Cost	PMM			$25.00	$25.75	$26.52	$27.32	$28.14
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Emergency Room	PMM			$24.00	$24.72	$25.46	$26.23	$27.01
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Emergency Room Visits Per Month					-	-	-	-
Cost Per Visit				$ -	$0.00	$0.00	$0.00	$0.00
Purchased Service - Nursing Home	% of Cap Days			1.00%	3.00%	4.00%	6.00%	7.00%
	Days			98	956	1,810	2,716	3,168
	Daily Rate			$200.00	$206.00	$212.18	$218.55	$225.10
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Supportive Housing /Assisted Living	% of Cap Days			2.000%	3.000%	4.000%	5.000%	5.000%
	Days			196	956	1,810	2,263	2,263
	Daily Rate			$110.00	$113.30	$116.70	$120.20	$123.81
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Purchased Service - Other	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense	PMM			$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Administration	**Enrollee's Per F.T.E.**			**5.1**	**16.6**	**23.6**	**23.6**	**23.6**
Total Cost Per Member Month				$ 2,878.40	$ 975.88	$ 741.61	$ 778.38	$ 810.62
Other Expense (Minor Equipment, Postage, Misc)	Monthly	14	$ 2,000	$2,000.00	$2,266.00	$2,567.38	$2,908.84	$3,295.71
	Experience Adjustment				10.0%	10.0%	10.0%	10.0%
Bad Debt	% of Revenue			0.20%	0.20%	0.20%	0.20%	0.20%
Insurance and Taxes	Monthly	14	$ 1,000	$1,200.00	$1,236.00	$1,273.08	$1,311.27	$1,350.61
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Malpractice Insurance	Monthly	-	$ -	$1,500.00	$1,776.75	$2,104.56	$2,492.85	$2,567.64
	Experience Adjustment				15.0%	15.0%	15.0%	0.0%
Reinsurance	Monthly	-	$ -	$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Corporate Overhead Cost	% of Revenue			0.0%	0.0%	0.0%	0.0%	0.0%
NPA Dues (Based on Fee Schedule)	Monthly		$ -	$1,000.00	$ 950.00	$ 975.00	$ 1,000.00	$ 1,025.00
	Ann Rev in 000's			$ 2,019	$ 6,736	$ 9,798	$ 10,069	$ 10,348
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Part D Premium Actuarial Expense	Monthly	12	$ 2,000	$1,200.00	$1,236.00	$1,273.08	$1,311.27	$1,350.61
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Consulting Fees	Monthly	12	$ 3,000	$1,500.00	$1,545.00	$1,591.35	$1,639.09	$1,688.26
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Medicare Health Outcomes Survey	Monthly	-	$ -	$125.00	$128.75	$132.61	$136.59	$140.69
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Office Supplies	Monthly	14	$ 250	$200.00	$206.00	$212.18	$218.55	$225.10
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Travel	Monthly	12	$ 500	$1,000.00	$1,236.00	$1,464.04	$1,734.16	$2,054.11
	Experience Adjustment				20.0%	15.0%	15.0%	15.0%
Communications	Monthly	12	$ 200	$400.00	$453.20	$513.48	$581.77	$659.14
	Experience Adjustment				10.0%	10.0%	10.0%	10.0%
Purchased Services	Monthly	14	$ 1,000	$2,500.00	$2,832.50	$3,646.84	$4,695.31	$5,319.79
	Experience Adjustment				10.0%	25.0%	25.0%	10.0%
Marketing	**Enrollee's Per F.T.E.**			**26.9**	**87.3**	**124.0**	**124.0**	**124.0**
Total Cost Per Member Month				$ 120.74	$ 38.33	$ 27.81	$ 28.64	$ 29.50
Purchased Service	Monthly	13	$ 4,000	$2,500.00	$2,575.00	$2,652.25	$2,731.82	$2,813.77
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Supplies, Advertising, Travel, PR, Printing)	Monthly			$750.00	$772.50	$795.68	$819.55	$844.13
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%

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Operating Expense Assumption

	Cost Basis			Year 1	Year 2	Year 3	Year 4	Year 5
	Member Months	Start Up Period	Monthly Start Up Costs	323	1,048	1,488	1,488	1,488
	Inflation			3.0%	3.0%	3.0%	3.0%	3.0%
Information Systems	**Enrollee's Per F.T.E.**			**13.5**	**43.7**	**62.0**	**62.0**	**62.0**
Total Cost Per Member Month				$ 679.22	$ 215.63	$ 156.43	$ 161.12	$ 165.97
Purchased Service	Monthly			$2,500.00	$2,575.00	$2,652.25	$2,731.82	$2,813.77
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Other Expense (Software, etc.)	Monthly			$1,500.00	$1,545.00	$1,591.35	$1,639.09	$1,688.26
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Medical Records	**Enrollee's Per F.T.E.**			**26.9**	**87.3**	**124.0**	**124.0**	**124.0**
Total Cost Per Member Month				$ 174.82	$ 61.91	$ 47.74	$ 49.18	$ 50.67
Other Expense (Supplies, Misc Other)	PMM	-	$ -	$9.00	$9.27	$9.55	$9.83	$10.13
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Plant Operations	**Enrollee's Per F.T.E.**			**13.5**	**43.7**	**62.0**	**62.0**	**62.0**
Total Cost Per Member Month				$ 1,730.94	$ 539.38	$ 381.67	$ 383.50	$ 385.41
Lease Rate	Per Square Foot			$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 30.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Square Footage - Total				15,000	15,000	15,000	15,000	15,000
Maintenance, Water/Sewer, Utilities	Monthly	12	$ 700	$1,950.00	$2,250.00	$2,250.00	$2,250.00	$2,250.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%
Pastoral Care	**Enrollee's Per F.T.E.**			**53.8**	**174.7**	**248.0**	**248.0**	**248.0**
Total Cost Per Member Month				$ 103.64	$ 32.90	$ 23.87	$ 24.58	$ 25.32
Other Expense (Supplies, Misc Other)	PMM	-	$ -	$0.00	$0.00	$0.00	$0.00	$0.00
	Experience Adjustment				0.0%	0.0%	0.0%	0.0%

Fairfax PACE
PACE Proforma & Five Year Projecton
Capital Assumptions

		Depreciate	N					
			2009	2010	2011	2012	2013	2014
	Months of CIP	15	Start Up					
CAPITAL PURCHASES		Useful Life	Costs	Year 1	Year 2	Year 3	Year 4	Year 5
Land								
Building		30						
Building Improvements		15						
Leasehold Improvements		20	1,200,000					
Fixed Equipment		10	67,000	5,000	5,000	5,000	5,000	5,000
Moveable Equipment		5	33,000	5,000	5,000	5,000	5,000	5,000
Computer Hardware		3	35,000	10,000	10,000	10,000	10,000	10,000
Vans		4		0	0	0	0	0
Total Capital Purchases			1,335,000	$20,000	$20,000	$20,000	$20,000	$20,000
PACE Center Attendees Per Van	9		New Vehicles	0	0	0	0	0
Total Vans				0	0	0	0	0
Van Purchased By Center (Y/N)				n	n	n	n	n
			Replacements				0	0
Cost per Van				$50,000	$ 51,500	$ 53,045	$ 54,636	$ 56,275
DEPRECIATION EXPENSE								
Building			-	-	-	-	-	-
				-	-	-	-	-
					-	-	-	-
						-	-	-
							-	-
								-
		Total	-	-	-	-	-	-
Building Improvements			-	-	-	-	-	-
				-	-	-	-	-
					-	-	-	-
						-	-	-
							-	-
								-
		Total	-	-	-	-	-	-
Leasehold Improvements			-	60,000	60,000	60,000	60,000	60,000
				-	-	-	-	-
					-	-	-	-
						-	-	-
							-	-
								-
		Total	-	60,000	60,000	60,000	60,000	60,000
Fixed Equipment			-	6,700	6,700	6,700	6,700	6,700
				500	500	500	500	500
					500	500	500	500
						500	500	500
							500	500
								500
		Total	-	7,200	7,700	8,200	8,700	9,200
Moveable Equipment			-	6,600	6,600	6,600	6,600	6,600
				1,000	1,000	1,000	1,000	1,000
					1,000	1,000	1,000	1,000
						1,000	1,000	1,000
							1,000	1,000
								1,000
		Total	-	7,600	8,600	9,600	10,600	11,600
Computer Hardware			-	11,667	11,667	11,667	-	-
				3,333	3,333	3,333	-	-
					3,333	3,333	3,333	-
						3,333	3,333	3,333
							3,333	3,333
								3,333
		Total	-	15,000	18,333	21,667	10,000	10,000
Vans			-	-	-	-	-	-
				-	-	-	-	-
					-	-	-	-
						-	-	-
							-	-
								-
		Total	-	-	-	-	-	-
Total Depreciation			-	89,800	94,633	99,467	89,300	90,800
		Cost PMM	$ -	$ 278.02	$ 90.30	$ 66.85	$ 60.01	$ 61.02

Fairfax PACE
PACE Proforma & Five Year Projecton
Financing Assumptions

				Year 1	Year 2	Year 3	Year 4	Year 5
	Contribtion Month ->							
Equity Contribution/Transfer From Sponser								
Mortgage Financing	Principal	-						
	Interest Rate	0.00%						
	Term (Yrs)	30	Interest	-	-	-	-	-
	Payment/Month	$0.00	Principal	-	-	-	-	-
				-	-	-	-	-
				-				
		Current Portion		-	-	-	-	-
		Non-Current Portion		-	-	-	-	-
				-	-	-	-	-
				-	-	-	-	-
	Interest Costs			-	-	-	-	-
Debt Financing	Total Debt		-	-	-	-	-	-
	Annual Payment							
	Interest Rate	0.00%						
	Interest Costs		**Years**	-	-	-	-	-
	Issuance Costs		20	-	-	-	-	-
Line of Credit	Draws		2,000,000	2,400,000	850,000			
	(Repayments)					(800,000)	(750,000)	(800,000)
	Net Due		2,000,000	4,400,000	5,250,000	4,450,000	3,700,000	2,900,000
	Interest Costs			160,000	241,250	262,500	222,500	185,000
	Interest Rate			5.00%	5.00%	5.00%	5.00%	5.00%
Contributions/Grants		**Start Up**						
Temporarily Restricted Assets/Grants Received		**Month**						
Beginning Balance				$ -	$ -	$ -	$ -	$ -
Contributions Received								
Net Assets Released From Restrictions For Operating Purposes								
Net Assets Released From Restrictions For Purchase of Plant, Property & Equipment								
Ending Balance			-	-	-	-	-	-
Permanently Restricted Assets								
Beginning Balance				$ -	$ -	$ -	$ -	$ -
Contributions Received			-	-	-	-	-	-
Interest Earnings			-	-	-	-	-	-
Net Assets Released From Restrictions For Operating Purposes			-	-	-	-	-	-
Ending Balance			-	-	-	-	-	-
Unrestricted Contributions								
Partnerships Contributions								
Beginning Balance				$ -	$ -	$ -	$ -	$ -
Contributions Received				-	-	-	-	-
Distributions			-					
Other			-	-	-	-	-	-
			-	-	-	-	-	-
Ending Balance			-	-	-	-	-	-

Fairfax PACE
PACE Proforma & Five Year Projecton
Balance Sheet Assumptions

		Year 1	Year 2	Year 3	Year 4	Year 5
Cash & Cash Equivalents		300,000	300,000	300,000	300,000	300,000
Debt Service Reserve						
Other Reserves						
Required Reserve Calculation						
Total Capitation Revenues		338,017	755,874	816,489	839,116	862,342
Average Payment to All Contractors		133,047	308,360	359,541	385,712	399,650
Required Reserve Calculation		471,064	1,064,234	1,176,030	1,224,828	1,261,992
Reserves & Investments-Beginning		124,295	194,866	778,955	903,424	969,309
Change In Cash		70,571	584,088	124,469	65,885	(4,957)
Investment Earnings Rate		0.00%	0.00%	0.00%	0.00%	0.00%
Reserves & Investments-Ending		194,866	778,955	903,424	969,309	964,351
		-	-	-	-	-
Days in Accounts Receivable	15	15	15	15	15	15
Days in Prepaid Expenses						
Days in Inventory						
Days in Accounts Payable	30	30	30	30	30	30
Accrued Salaries & Benefits	5	5	5	5	5	5
IBNR Liability	5	20	20	25	30	30

Appendix G

Fairfax Financial Proforma

Personnel and Staffing Assumptions

Fairfax PACE
PACE Proforma & Five Year Projecton
Staffing Assumptions

	Start Up	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Inflation Assumptions	0.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Employee Benefits as % of Salary	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Non-Productive Hours %	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

	Year 1	Year 2	Year 3	Year 4	Year 5
Average Daily Attendance	16	52	74	74	74
Average Enrollment	27	87	124	124	124
Total F.T.E.'s	26.1	34.4	38.8	38.8	38.8
Participants per F.T.E	1.0	2.5	3.2	3.2	3.2

Purchased Service Indicator

DEPARTMENT	POSITION NAME	Base Hourly Rate	Annual Salary	Start Up Period	Start Up F.T.E.	Staffing Basis	Base		Staffing Ratio Year 1	Year 2	Year 3	Year 4	Year 5	Average FTE's Year 1	Year 2	Year 3	Year 4	Year 5	Enter Y(Yes) or N(No) Year 1	Year 2	Year 3	Year 4	Year 5
Transportation	Transportation Coordinator	**$18.00**	$37,440	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Transportation						ADA		1:						-	-	-	-	-	N	N	N	N	N
Transportation						ADA		1:						-	-	-	-	-	N	N	N	N	N
Transportation						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Transportation						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Nursing	RN	**$37.00**	$76,960	16	1.0	Census	1.0	1:	50.0	50.0	50.0	50.0	50.0	1.1	2.0	2.5	2.5	2.5	N	N	N	N	N
Nursing						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Nursing						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Nursing						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Nursing						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Nutrition	Dietitian	**$32.00**	$66,560		0.5	Fixed	0.5	1:	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	N	N	N	N	N
Nutrition						Census		1:						-	-	-	-	-	N	N	N	N	N
Nutrition						Census		1:						-	-	-	-	-	N	N	N	N	N
Nutrition						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Social Services	Social Worker (MSW)	**$30.00**	$62,400	17	1.0	Census	1.0	1:	40.0	40.0	40.0	40.0	40.0	1.2	2.5	3.1	3.1	3.1	N	N	N	N	N
Recreational Therapy	Recreational Therapy Coordinator	**$25.00**	$52,000	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Recreational Therapy						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Restorative Therapy	Physical Therapist	**$46.00**	$95,680	17	0.25	Census	0.25	1:	150.0	150.0	150.0	150.0	150.0	0.30	0.65	0.80	0.80	0.80	Y	Y	Y	Y	Y
Restorative Therapy	Speech Language Pathologist	**$46.00**	$95,680	18	0.25	Fixed	0.25	1:	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	Y	Y	Y	Y	Y
Restorative Therapy	Occupational Therapist	**$46.00**	$95,680	17	0.25	Census	0.25	1:	150.0	150.0	150.0	150.0	150.0	0.30	0.65	0.80	0.80	0.80	Y	Y	Y	Y	Y
Restorative Therapy						Census		1:						-	-	-	-	-	N	N	N	N	N
Restorative Therapy						Census		1:						-	-	-	-	-	N	N	N	N	N
Restorative Therapy						Census		1:						-	-	-	-	-	N	N	N	N	N
Center Support	Center Manager	**$47.00**	$97,760	15	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Center Support						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Center Support	PACE Center Workers/C.N.A.	**$16.00**	$33,280	18	2.0	ADA	1.0	1:	10.0	10.0	10.0	10.0	10.0	2.0	5.5	7.4	7.4	7.4	N	N	N	N	N
Center Support	PACE Center Receptionist	**$18.00**	$37,440	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Center Support						Fixed		1:						-	-	-	-	-	N	N	N	N	N
In-Home Services	Home Care Coordinator	**$30.00**	$62,400	17	1.0	Census	1.0	1:	50.0	50.0	50.0	50.0	50.0	1.1	2.0	2.5	2.5	2.5	N	N	N	N	N
In-Home Services						Census		1:						-	-	-	-	-	N	N	N	N	N
In-Home Services						Census		1:						-	-	-	-	-	Y	Y	Y	Y	Y
In-Home Services						Fixed		1:						-	-	-	-	-	N	N	N	N	N
In-Home Services						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Pharmacy	Pharmacist	**$50.00**	$104,000			Fixed	0.25	1:	0.25	0.25	0.25	0.25	0.25	0.3	0.3	0.3	0.3	0.3	Y	Y	Y	Y	Y
Pharmacy						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Primary Care	Staff Physician	**$90.00**	$187,200	17	0.75	Census	0.75	1:	150.00	150.00	150.00	150.00	150.00	0.8	0.8	0.8	0.8	0.8	N	N	N	N	N
Primary Care	Nurse Practitioner	**$40.00**	$83,200			Census	0.5	1:	150.0	150.0	150.0	150.0	150.0	0.5	0.7	0.8	0.8	0.8	N	N	N	N	N
Primary Care						Census		1:						-	-	-	-	-	N	N	N	N	N
Administration	Program Director	**$60.00**	$124,800	12	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Administration	Medical Director	**$90.00**	$187,200	13	0.25	Fixed	0.25	1:	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	N	N	N	N	N
Administration			$0			Fixed		1:						-	-	-	-	-	N	N	N	N	N
Administration	Intake Coordinator	**$30.00**	$62,400	16	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration	Quality Assurance Coordinator	**$38.00**	$79,040	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration	Administrative Assistant	**$27.00**	$56,160	13	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration	Staff Accountant	**$42.00**	$87,360	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Administration						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Information Systems	IT Specialist	**$44.00**	$91,520	17	1.0	Fixed	0.5	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Administration						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Administration						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Marketing	Director of Marketing	**$40.00**	$83,200	16	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Information Systems	Data Entry	**$20.00**	$41,600	18	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Medical Records						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Medical Records	Medical Records Clerk	**$20.00**	$41,600	18	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Plant Operations	Housekeeper	**$12.00**	$24,960	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Plant Operations	Maintenance Worker	**$20.00**	$41,600	17	1.0	Fixed	1.0	1:	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	N	N	N	N	N
Plant Operations						Fixed		1:						-	-	-	-	-	N	N	N	N	N
Pastoral Care	Chaplain	**$25.00**	$52,000		0.5	Fixed	0.5	1:	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N
						Fixed		1:						-	-	-	-	-	N	N	N	N	N

Fairfax PACE
PACE Proforma & Five Year Projecton
Staffing Assumptions

	Start Up	Year 1	Year 2	Year 3	Year 4	Year 5
Salary Inflation Assumptions	0.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Employee Benefits as % of Salary	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
Non-Productive Hours %	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

	Year 1	Year 2	Year 3	Year 4	Year 5
Average Daily Attendance	16	52	74	74	74
Average Enrollment	27	87	124	124	124
Total F.T.E.'s	26.1	34.4	38.8	38.8	38.8
Participants per F.T.E	1.0	2.5	3.2	3.2	3.2

DEPARTMENT	POSITION NAME	Base Hourly Rate	Annual Salary	Start Up Period	Start Up F.T.E.	Staffing Basis	Base	Staffing Ratio Year 1	Staffing Ratio Year 2	Staffing Ratio Year 3	Staffing Ratio Year 4	Staffing Ratio Year 5	Average FTE's Year 1	Average FTE's Year 2	Average FTE's Year 3	Average FTE's Year 4	Average FTE's Year 5	Purchased Service Indicator Year 1	Year 2	Year 3	Year 4	Year 5
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
						Fixed	1:						-	-	-	-	-	N	N	N	N	N
													23.8	31.4	35.5	35.5	35.5					
													(0)	-	(0)	(0)	(0)					

Fairfax PACE
PACE Proforma & Five Year Projecton
Summary Staffing Schedule

Staffing Costs	Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
Transportation	38,563	39,727	40,913	42,140	43,409	1.0	1.0	1.0	1.0	1.0
Nursing	83,231	160,557	210,233	216,525	223,025	1.1	2.0	2.5	2.5	2.5
Nutrition	34,278	35,307	36,368	37,460	38,583	0.5	0.5	0.5	0.5	0.5
Social Services	73,912	162,755	211,362	217,681	224,194	1.2	2.5	3.1	3.1	3.1
Recreational Therapy	53,559	55,161	56,825	58,530	60,278	1.0	1.0	1.0	1.0	1.0
Restorative Therapy	-	-	-	-	-	-	-	-	-	-
Center Support	206,953	339,040	416,789	429,223	442,110	4.0	7.5	9.4	9.4	9.4
In-Home Services	67,485	130,204	170,454	175,549	180,801	1.1	2.0	2.5	2.5	2.5
Pharmacy	-	-	-	-	-	-	-	-	-	-
Primary Care	187,457	208,807	236,368	243,456	250,761	1.3	1.4	1.6	1.6	1.6
Administration	470,250	484,342	498,870	513,862	529,274	5.3	5.3	5.3	5.3	5.3
Marketing	-	-	-	-	-	1.0	1.0	1.0	1.0	1.0
Information Systems	137,112	141,230	145,473	149,841	154,355	2.0	2.0	2.0	2.0	2.0
Medical Records	42,847	44,137	45,468	46,841	48,255	1.0	1.0	1.0	1.0	1.0
Plant Operations	68,556	70,615	72,737	74,921	77,188	2.0	2.0	2.0	2.0	2.0
Pastoral Care	26,780	27,580	28,412	29,265	30,139	0.5	0.5	0.5	0.5	0.5
Admin. (Non-Productive)	149,098	189,946	217,027	223,529	230,237	2.3	3.0	3.3	3.3	3.3
Total Salaries	1,640,081	2,089,409	2,387,299	2,458,824	2,532,609	25.0	32.6	36.7	36.7	36.7

Contract Labor	Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
Transportation	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-
Nutrition	-	-	-	-	-	-	-	-	-	-
Social Services	-	-	-	-	-	-	-	-	-	-
Recreational Therapy	-	-	-	-	-	-	-	-	-	-
Restorative Therapy	83,767	157,329	193,398	199,208	205,172	0.9	1.6	1.9	1.9	1.9
Center Support	-	-	-	-	-	-	-	-	-	-
In-Home Services	-	-	-	-	-	-	-	-	-	-
Pharmacy	26,780	27,586	28,412	29,265	30,144	0.3	0.3	0.3	0.3	0.3
Primary Care	-	-	-	-	-	-	-	-	-	-
Administration	-	-	-	-	-	-	-	-	-	-
Marketing	-	-	-	-	-	-	-	-	-	-
Information Systems	-	-	-	-	-	-	-	-	-	-
Medical Records	-	-	-	-	-	-	-	-	-	-
Plant Operations	-	-	-	-	-	-	-	-	-	-
Pastoral Care	-	-	-	-	-	-				
Total Salaries	$110,546	$184,915	$221,810	$228,473	$235,316	1.1	1.8	2.1	2.1	2.1
Grand Total	$1,750,628	$2,274,324	$2,609,109	$2,687,298	$2,767,925	26.1	34.4	38.8	38.8	38.8
Cost Per F.T.E	$67,080	$66,200	$67,271	$69,287	$71,366					
Increase %		-1.3%	1.6%	3.0%	3.0%					

Appendix H

Fairfax Financial Proforma

Financial Statements

Fairfax PACE
Annual Projections

DETAILED INCOME STATEMENT (page 1)

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
Member Months	-	323	1,048	1,488	1,488	1,488
Attendance Days	-	4,199	13,624	19,344	19,344	19,344
Average Daily Attendance	-	16	52	74	74	74
OPERATING REVENUES						
Medicare Capitation	-	$777,857	$2,551,176	$3,620,860	$3,648,138	$3,672,911
Medicaid Capitation	-	1,191,165	4,018,160	5,929,350	6,163,692	6,407,331
Private Pay	-	49,610	166,690	247,654	257,560	267,862
Other	-	-	-	-	-	-
	-	-	-	-	-	-
TOTAL CAPITATION REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
Other Operating Revenues	-	-	-	-	-	-
Transfer From Restricted For Operating Purposes	-	-	-	-	-	-
Interest Income	-	-	-	-	-	-
TOTAL OPERATING REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
OPERATING EXPENSES						
Transportation						
Salaries and wages	$ 6,240	$ 38,563	$ 39,727	$ 40,913	$ 42,140	$ 43,409
Contract Labor	-	-	-	-	-	-
Employee benefits	1,560	9,641	9,932	10,228	10,535	10,852
Purchased Service	-	167,960	561,309	820,882	845,508	870,874
Other Expense (Maintenance,Gas & Oil, Supplies, Misc Other)	-	33,592	112,262	164,176	169,102	174,175
Total Expenses:	$ 7,800	$ 249,756	$ 723,230	$ 1,036,200	$ 1,067,285	$ 1,099,310
Nursing						
Salaries and wages	$ 19,240	$ 83,231	$ 160,557	$ 210,233	$ 216,525	$ 223,025
Contract Labor	-	-	-	-	-	-
Employee benefits	4,810	20,808	40,139	52,558	54,131	55,756
Purchased Service	-	-	-	-	-	-
Other Expense (Supplies, Equipment, Misc Other)	-	646	2,159	3,157	3,252	3,350
Total Expenses:	$ 24,050	$ 104,685	$ 202,855	$ 265,948	$ 273,908	$ 282,130
Nutrition						
Salaries and wages	$ -	$ 34,278	$ 35,307	$ 36,368	$ 37,460	$ 38,583
Contract Labor	-	-	-	-	-	-
Employee benefits	-	8,569	8,827	9,092	9,365	9,646
Purchased Service	-	17,765	59,369	86,824	89,429	92,112
Other Expense (Supplies, Food, Supplements, Misc Other)	2,000	3,876	12,953	18,943	19,512	20,097
Total Expenses:	$ 2,000	$ 64,488	$ 116,457	$ 151,228	$ 155,766	$ 160,438
Social Services						
Salaries and wages	$ 10,400	$ 73,912	$ 162,755	$ 211,362	$ 217,681	$ 224,194
Contract Labor	-	-	-	-	-	-
Employee benefits	2,600	18,478	40,689	52,841	54,420	56,048
Purchased Service	-	-	-	-	-	-
Other Expense (Travel, Conferences, Misc Other)	1,000	1,131	3,778	5,525	5,691	5,862
Total Expenses:	$ 14,000	$ 93,520	$ 207,222	$ 269,728	$ 277,793	$ 286,104
Recreational Therapy						
Salaries and wages	$ 8,667	$ 53,559	$ 55,161	$ 56,825	$ 58,530	$ 60,278
Contract Labor	-	-	-	-	-	-
Employee benefits	2,167	13,390	13,790	14,206	14,633	15,069
Purchased Service	-	-	-	-	-	-
Other Expense (Supplies, Misc Other)	1,200	646	2,159	3,157	3,252	3,350
Total Expenses:	$ 12,033	$ 67,595	$ 71,110	$ 74,188	$ 76,415	$ 78,696
Restorative Therapy						
Salaries and wages	$ -	$ -	$ -	$ -	$ -	$ -
Contract Labor	9,967	83,767	157,329	193,398	199,208	205,172
Employee benefits	-	-	-	-	-	-
Purchased Service	-	-	-	-	-	-
Other Expense (Supplies, Equipment, Misc Other)	-	1,615	5,397	7,893	8,130	8,374
Total Expenses:	$ 9,967	$ 85,382	$ 162,726	$ 201,291	$ 207,338	$ 213,546
Center Support						
Salaries and wages	$ 44,374	$ 206,953	$ 339,040	$ 416,789	$ 429,223	$ 442,110
Contract Labor	-	-	-	-	-	-
Employee benefits	11,093	51,738	84,760	104,197	107,306	110,528
Purchased Service	-	-	-	-	-	-
Other Expense (Supplies, Travel, Equipment, Misc Other)	-	12,920	43,178	63,145	65,039	66,990
Total Expenses:	$ 55,467	$ 271,611	$ 466,977	$ 584,130	$ 601,567	$ 619,628

Fairfax PACE
Annual Projections

DETAILED INCOME STATEMENT (page 2)

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
Member Months	-	323	1,048	1,488	1,488	1,488
Attendance Days	-	4,199	13,624	19,344	19,344	19,344
Average Daily Attendance	-	16	52	74	74	74
In-Home Services						
Salaries and wages	$ 10,400	$ 67,485	$ 130,204	$ 170,454	$ 175,549	$ 180,801
Contract Labor	-	-	-	-	-	-
Employee benefits	2,600	16,871	32,551	42,613	43,887	45,200
Purchased Service - Skilled Care	-	2,326	7,772	11,366	11,707	12,058
Purchased Service - Other (Aides, Sitters, Misc Other)	-	129,200	431,776	631,448	650,391	669,903
Other Expense - DME	-	9,690	32,383	47,359	48,779	50,243
Other Expense (Supplies, Travel, Misc Other)	-	9,690	32,383	47,359	48,779	50,243
Total Expenses:	$ 13,000	$ 235,261	$ 667,070	$ 950,598	$ 979,094	$ 1,008,448
Pharmacy						
Salaries and wages	$ -	$ -	$ -	$ -	$ -	$ -
Contract Labor	-	26,780	27,586	28,412	29,265	30,144
Employee benefits	-	-	-	-	-	-
Purchased Service - Dispensing	-	14,535	49,983	75,218	79,721	84,494
Covered Part D Drugs	-	137,275	458,762	670,913	691,041	711,772
Non-Covrered Part D Drugs	-	-	-	-	-	-
Other Expense	-	-	-	-	-	-
Total Expenses:	$ -	$ 178,590	$ 536,331	$ 774,543	$ 800,027	$ 826,410
Primary Care						
Salaries and wages	$ 23,400	$ 187,457	$ 208,807	$ 236,368	$ 243,456	$ 250,761
Contract Labor	-	-	-	-	-	-
Employee benefits	5,850	46,864	52,202	59,092	60,864	62,690
Purchased Service	-	-	-	-	-	-
On Call Expense	-	132,000	135,960	140,039	144,240	148,567
Total Expenses:	$ 29,250	$ 366,322	$ 396,969	$ 435,499	$ 448,560	$ 462,019
Routine Specialists						
Salaries and wages	$ -	$ -	$ -	$ -	$ -	$ -
Contract Labor	-	-	-	-	-	-
Employee benefits	-	-	-	-	-	-
Purchased Service (Audiology, Dentist, Optometrist, Podiatry, Psychiatry, etc.)	-	7,106	23,748	34,730	35,772	36,845
Other Expense	-	-	-	-	-	-
Total Expenses:	$ -	$ 7,106	$ 23,748	$ 34,730	$ 35,772	$ 36,845
Outpatient Services						
Salaries and wages	$ -	$ -	$ -	$ -	$ -	$ -
Contract Labor	-	-	-	-	-	-
Employee benefits	-	-	-	-	-	-
Purchased Service - Radiology	-	8,075	26,986	39,465	40,649	41,869
Purchased Service - Laboratory	-	11,305	37,780	55,252	56,909	58,616
Purchased Service - Dialysis	-	36,000	61,800	74,160	74,160	74,160
Purchased Service - O/P Surgery	-	29,070	97,150	142,076	146,338	150,728
Purchased Service - Other (End of Life)	-	-	-	-	-	-
Other Expense	-	-	-	-	-	-
Total Expenses:	$ -	$ 84,450	$ 223,716	$ 310,953	$ 318,057	$ 325,374
Inpatient Services						
Salaries and wages	$ -	$ -	$ -	$ -	$ -	$ -
Contract Labor	-	-	-	-	-	-
Employee benefits	-	-	-	-	-	-
Purchased Service - Acute Hospital	-	183,033	575,701	789,310	731,690	669,903
Purchased Service - I/P Specialist Cost	-	4,845	16,192	23,679	24,390	25,121
Purchased Service - Ambulance Cost	-	8,075	26,986	39,465	40,649	41,869
Purchased Service - Emergency Room	-	7,752	25,907	37,887	39,023	40,194
Purchased Service - Nursing Home	-	19,400	197,142	384,470	592,695	713,122
Purchased Service - Supportive Housing	-	21,780	108,428	211,459	272,614	280,792
Purchased Service - Other	-	-	-	-	-	-
Other Expense	-	-	-	-	-	-
Total Expenses:	$0	$244,885	$950,356	$1,486,270	$1,701,061	$1,771,002

Fairfax PACE
Annual Projections

DETAILED INCOME STATEMENT (page 3)

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
Member Months	-	323	1,048	1,488	1,488	1,488
Attendance Days	-	4,199	13,624	19,344	19,344	19,344
Average Daily Attendance	-	16	52	74	74	74
Administration						
Salaries and wages	$ 167,614	$ 470,250	$ 484,342	$ 498,870	$ 513,862	$ 529,274
Non-Productive	26,728	149,098	189,946	217,027	223,529	230,237
Contract Labor	-	-	-	-	-	-
Employee benefits	48,586	154,837	168,572	178,974	184,348	189,878
Purchased Service	10,000	24,000	27,192	30,809	34,906	39,549
Bad Debt	-	4,037	13,472	19,596	20,139	20,696
Insurance and Taxes	5,000	14,400	14,832	15,277	15,735	16,207
Malpractice Insurance	-	18,000	21,321	25,255	29,914	30,812
Reinsurance	-	-	-	-	-	-
Corporate Overhead Cost	-	-	-	-	-	-
NPA Dues (Based on Fee Schedule)	-	12,000	11,400	11,700	12,000	12,300
Part D Premium Actuarial Expense	14,000	14,400	14,832	15,277	15,735	16,207
Consulting Fees	21,000	18,000	18,540	19,096	19,669	20,259
Medicare Health Outcomes Survey	-	1,500	1,545	1,591	1,639	1,688
Office Supplies	1,250	2,400	2,472	2,546	2,623	2,701
Travel	3,500	12,000	14,832	17,569	20,810	24,649
Communications	1,400	4,800	5,438	6,162	6,981	7,910
Other Expense (Equipment, Supplies, Misc)	5,000	30,000	33,990	43,762	56,344	63,837
Total Expenses:	$ 304,078	$ 929,723	$ 1,022,727	$ 1,103,511	$ 1,158,234	$ 1,206,206
Marketing						
Salaries and wages	$ 20,800	$ -	$ -	$ -	$ -	$ -
Contract Labor	-	-	-	-	-	-
Employee benefits	5,200	-	-	-	-	-
Purchased Service	24,000	30,000	30,900	31,827	32,782	33,765
Other Expense (Supplies, Advertising, Travel, PR, Printing)	-	9,000	9,270	9,548	9,835	10,130
Total Expenses:	$ 50,000	$ 39,000	$ 40,170	$ 41,375	$ 42,616	$ 43,895
Information Systems						
Salaries and wages	$ 18,720	$ 137,112	$ 141,230	$ 145,473	$ 149,841	$ 154,355
Contract Labor	-	-	-	-	-	-
Employee benefits	4,680	34,278	35,307	36,368	37,460	38,589
Purchased Service	-	30,000	30,900	31,827	32,782	33,765
Other Expense (Software, Consulting, Supplies, Misc Other)	-	18,000	18,540	19,096	19,669	20,259
Total Expenses:	$ 23,400	$ 219,390	$ 225,977	$ 232,765	$ 239,752	$ 246,968
Medical Records						
Salaries and wages	$ 3,467	$ 42,847	$ 44,137	$ 45,468	$ 46,841	$ 48,255
Contract Labor	-	-	-	-	-	-
Employee benefits	867	10,712	11,034	11,367	11,710	12,064
Other Expense (Supplies, Misc Other)	-	2,907	9,715	14,208	14,634	15,073
Total Expenses:	$4,334	$56,466	$64,886	$71,043	$73,185	$75,392
Plant Operations						
Salaries and wages	$ 11,093	$ 68,556	$ 70,615	$ 72,737	$ 74,921	$ 77,188
Contract Labor	-	-	-	-	-	-
Employee benefits	2,773	17,139	17,654	18,184	18,730	19,297
Rent, Facility, and Maintenance	-	450,000	450,000	450,000	450,000	450,000
Other Expense	4,900	23,400	27,000	27,000	27,000	27,000
Total Expenses:	$ 18,767	$ 559,095	$ 565,269	$ 567,921	$ 570,651	$ 573,485
Pastoral Care						
Salaries and wages	$ -	$ 26,780	$ 27,580	$ 28,412	$ 29,265	$ 30,139
Contract Labor	-	-	-	-	-	-
Employee benefits	-	6,695	6,895	7,103	7,316	7,535
Other Expense (Supplies, Misc Other)	-	-	-	-	-	-
Total Expenses:	$0	$33,475	$34,476	$35,515	$36,581	$37,673
Depreciation Costs						
Depreciation	-	89,800	94,633	99,467	89,300	90,800
Total Expenses:	$0	$89,800	$94,633	$99,467	$89,300	$90,800
Interest Costs						
Interest	-	160,000	241,250	262,500	222,500	185,000
Total Expenses:	$0	$160,000	$241,250	$262,500	$222,500	$185,000
Total Expenses:	**568,147**	**4,140,600**	**7,038,154**	**8,989,402**	**9,375,462**	**9,629,367**
INCOME/(LOSS) FROM OPERATIONS:	**$ (568,147)**	**$ (2,121,967)**	**$ (302,128)**	**$ 808,461**	**$ 693,927**	**$ 718,738**
NON-OPERATING ACTIVITY						
Unrestricted Contributions	-	-	-	-	-	-
Other	0	0	0	0	0	-
TOTAL NON-OPERATING ACTIVITY:	-	-	-	-	-	-
NET INCOME/(LOSS):	$ (568,147)	$ (2,121,967)	$ (302,128)	$ 808,461	$ 693,927	$ 718,738
	-	-	-	-	-	-

Fairfax PACE
Annual Projections

SUMMARY INCOME STATEMENT BY EXPENSE CATEGORY

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
OPERATING REVENUES						
Medicare Capitation	$ -	$ 777,857	$ 2,551,176	$ 3,620,860	$ 3,648,138	$ 3,672,911
Medicaid Capitation	-	1,191,165	4,018,160	5,929,350	6,163,692	6,407,331
Private Pay	-	49,610	166,690	247,654	257,560	267,862
Other	-	-	-	-	-	-
	-	-	-	-	-	-
TOTAL CAPITATION REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
Other Operating Revenues	-	-	-	-	-	-
Transfer From Restricted For Operating Purposes	-	-	-	-	-	-
Interest Income	-	-	-	-	-	-
TOTAL OPERATING REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
OPERATING EXPENSES						
Adult Day Center						
Transporation	7,800	249,756	723,230	1,036,200	1,067,285	1,099,310
Nursing	24,050	104,685	202,855	265,948	273,908	282,130
Nutrition	2,000	64,488	116,457	151,228	155,766	160,438
Social Services	14,000	93,520	207,222	269,728	277,793	286,104
Recreational Therapy	12,033	67,595	71,110	74,188	76,415	78,696
Restorative Therapy	9,967	85,382	162,726	201,291	207,338	213,546
Center Support	55,467	271,611	466,977	584,130	601,567	619,628
	125,318	937,038	1,950,577	2,582,714	2,660,072	2,739,853
In-Home Services	13,000	235,261	667,070	950,598	979,094	1,008,448
Primary Care	29,250	366,322	396,969	435,499	448,560	462,019
Routine Specialists	-	7,106	23,748	34,730	35,772	36,845
Outpatient Services	-	84,450	223,716	310,953	318,057	325,374
Pharmacy	-	178,590	536,331	774,543	800,027	826,410
Inpatient Services	-	244,885	950,356	1,486,270	1,701,061	1,771,002
Sub-Total - Participant Costs:	167,568	2,053,652	4,748,766	6,575,306	6,942,642	7,169,949
Administration	304,078	929,723	1,022,727	1,103,511	1,158,234	1,206,206
Marketing	50,000	39,000	40,170	41,375	42,616	43,895
Information Systems	23,400	219,390	225,977	232,765	239,752	246,968
Medical Records	4,334	56,466	64,886	71,043	73,185	75,392
Plant Operations	18,767	559,095	565,269	567,921	570,651	573,485
Pastoral Care	-	33,475	34,476	35,515	36,581	37,673
Depreciation Costs	-	89,800	94,633	99,467	89,300	90,800
Interest Costs	-	160,000	241,250	262,500	222,500	185,000
Sub-Total - General & Administrative:	400,578	2,086,948	2,289,388	2,414,096	2,432,820	2,459,418
INCOME/(LOSS) FROM OPERATIONS:	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
NON-OPERATING ACTIVITY						
Unrestricted Contributions	-	-	-	-	-	-
Other	-	-	-	-	-	-
TOTAL NON-OPERATING ACTIVITY:	-	-	-	-	-	-
NET INCOME/(LOSS):	$ (568,147)	$ (2,121,967)	$ (302,128)	$ 808,461	$ 693,927	$ 718,738
	-	-	(0)	(0)	(0)	-

Fairfax PACE
Annual Projections

SUMMARY INCOME STATEMENT BY PER MEMBER PER MONTH

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
OPERATING REVENUES						
Medicare Capitation	$ -	$ 2,408.23	$ 2,434.33	$ 2,433.37	$ 2,451.71	$ 2,468.35
Medicaid Capitation	-	3,687.82	3,834.12	3,984.78	4,142.27	4,306.00
Private Pay	-	153.59	159.06	166.43	173.09	180.01
Other	-	-	-	-	-	-
0	-	-	-	-	-	-
TOTAL CAPITATION REVENUES:	-	6,249.64	6,427.51	6,584.59	6,767.06	6,954.37
Other Operating Revenues						
Transfer From Restricted For Operating Purposes	-	-	-	-	-	-
Interest Income	-	-	-	-	-	-
TOTAL OPERATING REVENUES:	-	6,249.64	6,427.51	6,584.59	6,767.06	6,954.37
OPERATING EXPENSES						
Adult Day Center						
Transporation	-	773.24	690.10	696.37	717.26	738.78
Nursing	-	324.10	193.56	178.73	184.08	189.60
Nutrition	-	199.65	111.12	101.63	104.68	107.82
Social Services	-	289.54	197.73	181.27	186.69	192.27
Recreational Therapy	-	209.27	67.85	49.86	51.35	52.89
Restorative Therapy	-	264.34	155.27	135.28	139.34	143.51
Center Support	-	840.90	445.59	392.56	404.28	416.42
	-	2,901.05	1,861.24	1,735.69	1,787.68	1,841.30
In-Home Services	-	728.36	636.52	638.84	657.99	677.72
Primary Care	-	1,134.12	378.79	292.67	301.45	310.50
Routine Specialists	-	22.00	22.66	23.34	24.04	24.76
Outpatient Services	-	261.46	213.47	208.97	213.75	218.67
Pharmacy	-	552.91	511.77	520.53	537.65	555.38
Inpatient Services	-	758.16	906.83	998.84	1,143.19	1,190.19
Sub-Total - Participant Costs:	-	6,358.06	4,531.27	4,418.89	4,665.75	4,818.51
Administration	-	2,878.40	975.88	741.61	778.38	810.62
Marketing	-	120.74	38.33	27.81	28.64	29.50
Information Systems	-	679.22	215.63	156.43	161.12	165.97
Medical Records	-	174.82	61.91	47.74	49.18	50.67
Plant Operations	-	1,730.94	539.38	381.67	383.50	385.41
Pastoral Care	-	103.64	32.90	23.87	24.58	25.32
Depreciation Costs	-	278.02	90.30	66.85	60.01	61.02
Interest Costs	-	495.36	230.20	176.41	149.53	124.33
Sub-Total - General & Administrative:	-	6,461.14	2,184.53	1,622.38	1,634.96	1,652.83
TOTAL OPERATING EXPENSES:	-	12,819.19	6,715.80	6,041.26	6,300.71	6,471.35
INCOME/(LOSS) FROM OPERATIONS:	-	(6,569.56)	(288.29)	543.32	466.35	483.02
NON-OPERATING ACTIVITY						
Unrestricted Contributions	-	-	-	-	-	-
Other	-	-	-	-	-	-
TOTAL NON-OPERATING ACTIVITY:	-	-	-	-	-	-
NET INCOME/(LOSS):	$ -	$ (6,569.56)	$ (288.29)	$ 543.32	$ 466.35	$ 483.02
		0.00	0.00	0.00	0.00	0.00

Fairfax PACE
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INCOME STATEMENT SUMMARY

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
OPERATING REVENUES						
Capitation Revenues-Medicare	-	$ 777,857	2,551,176	3,620,860	3,648,138	3,672,911
Capitation Revenues-Medicaid	-	1,191,165	4,018,160	5,929,350	6,163,692	6,407,331
Capitation Revenues-Other	-	49,610	166,690	247,654	257,560	267,862
	-	-	-	-	-	-
TOTAL CAPITATION REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
Other Operating Revenue	-	-	-	-	-	-
Transfer From Restricted For Operating Purposes	-	-	-	-	-	-
Interest Income	-	-	-	-	-	-
TOTAL OPERATING REVENUES:	-	2,018,633	6,736,026	9,797,863	10,069,390	10,348,105
OPERATING EXPENSES						
Salaries & Benefits	473,897	2,160,648	2,796,676	3,205,934	3,302,004	3,401,078
Supplies & Other Operating Expenses	15,250	728,313	919,879	1,046,882	1,067,327	1,088,971
Purchased Services	74,000	491,686	1,279,508	1,811,627	1,882,613	1,950,812
Medical Costs	-	473,716	1,656,581	2,502,866	2,745,930	2,844,992
Provision For Bad Debts	-	4,037	13,472	19,596	20,139	20,696
Insurance and Taxes	5,000	32,400	36,153	40,532	45,649	47,019
Depreciation	-	89,800	94,633	99,467	89,300	90,800
Interest Expense	-	160,000	241,250	262,500	222,500	185,000
TOTAL OPERATING EXPENSES:	568,147	4,140,600	7,038,154	8,989,402	9,375,462	9,629,367
INCOME/(LOSS) FROM OPERATIONS:	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
OTHER REVENUES/(EXPENSES)						
Unrestricted gifts and bequests	-	-	-	-	-	-
Other	-	-	-	-	-	-
TOTAL OTHER REVENUES (EXPENSES):	-	-	-	-	-	-
NET GAINS/LOSSES:	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
	-	-	0	-	-	(0)
Equity Transfer	-	-	-	-	-	-
Net Assets Released From Restrictions - Capital	-	-	-	-	-	-
Other	-	-	-	-	-	-
Change in Unrestricted Assets/Liablities	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738

Fairfax PACE
Annual Projections

BALANCE SHEET

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
ASSETS						
Current assets:						
Cash and temporary investments	-	300,000	300,000	300,000	300,000	300,000
Receivables:						
Accounts Receivable	-	169,009	377,937	408,244	419,558	431,171
Prepaid expenses	-	-	-	-	-	-
Other	-	-	-	-	-	-
Total current assets:	-	469,009	677,937	708,244	719,558	731,171
Board designated assets:						
Investment (Reserves)	124,295	194,866	778,955	903,424	969,309	964,351
Debt Service Reserves	-	-	-	-	-	-
Other	-	-	-	-	-	-
Total Board Designated Assets:	124,295	194,866	778,955	903,424	969,309	964,351
Land, Buildings and Equipment:						
Land	-	-	-	-	-	-
Building	-	-	-	-	-	-
Building Improvements	-	-	-	-	-	-
Leasehold Improvements	-	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000
Fixed Equipment	-	72,000	77,000	82,000	87,000	92,000
Moveable Equipment	-	38,000	43,000	48,000	53,000	58,000
Computers	-	45,000	55,000	65,000	75,000	85,000
Automobiles	-	-	-	-	-	-
Total Land, Buildings & Equipment:	-	1,355,000	1,375,000	1,395,000	1,415,000	1,435,000
Less: Accumulated Depreciation	-	(89,800)	(184,433)	(283,900)	(373,200)	(464,000)
Construction In Progress	1,335,000	-	-	-	-	-
Land, Buildings and Equipment, net:	1,335,000	1,265,200	1,190,567	1,111,100	1,041,800	971,000
Other Assets:						
Restricted assets	-	-	-	-	-	-
Notes, deposits, and other	-	-	-	-	-	-
Total Other Assets:	-	-	-	-	-	-
TOTAL ASSETS:	$ 1,459,295	$ 1,929,075	$ 2,647,458	$ 2,722,768	$ 2,730,667	$ 2,666,522
LIABILITIES AND NET ASSETS						
Current Liabilities:						
Current Portion Long Term Debt/LOC	-	-	-	-	-	-
Accounts Payable	-	135,919	223,271	238,209	245,828	253,315
Accrued Salaries and Wages	27,442	32,520	43,233	44,529	45,864	47,240
Accrued Expenses	-	-	-	-	-	-
Accrued Claims Payable (IBNR)	-	50,749	123,196	173,810	228,827	237,083
Line of Credit	2,000,000	4,400,000	5,250,000	4,450,000	3,700,000	2,900,000
Other Current Liabilities	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES:	2,027,442	4,619,188	5,639,700	4,906,548	4,220,519	3,437,638
Long Term Debt	-	-	-	-	-	-
Long-Term Debt, Excluding Current Installments	-	-	-	-	-	-
	-	-	-	-	-	-
Equity - Beginning of period:	-	(568,147)	(2,690,114)	(2,992,241)	(2,183,780)	(1,489,853)
- Net Income/(Loss)	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
- Unrealized Gains/(Losses)	-	-	-	-	-	-
- Resticted Net Assets	-	-	-	-	-	-
- Net Assets Released From Restrictions - Capital	-	-	-	-	-	-
- Partnership Contributions/(Distributions)	-	-	-	-	-	-
- Equity Transfers/Other	-	-	-	-	-	-
Equity - End of period:	(568,147)	(2,690,114)	(2,992,241)	(2,183,780)	(1,489,853)	(771,115)
TOTAL LIABILITIES & EQUITIES:	$ 1,459,295	$ 1,929,075	$ 2,647,458	$ 2,722,768	$ 2,730,667	$ 2,666,522
	-	-	-	-	-	-

STATEMENT OF CASH FLOWS

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
Cash flows from operating activities						
Change in unrestricted net assets	(568,147)	(2,121,967)	(302,128)	808,461	693,927	718,738
Adjustments to reconcile changes in net liabilities to net cash provided by operating activities:						
Transfer from affiliate	-	-	-	-	-	-
Extraordinary loss on early extinguishment of debt						
Depreciation and amortization	-	89,800	94,633	99,467	89,300	90,800
Restricted contributions received for specific purpose	-	-	-	-	-	-
Restricted Assets Released for Capital	-	-	-	-	-	-
Change in net unrealized gains and losses on other than trading securities						
Changes in assets and liabilities:						
Receivables	-	(169,009)	(208,928)	(30,307)	(11,314)	(11,613)
Prepaid expenses and other current assets	-	-	-	-	-	-
Accounts payable	-	135,919	87,352	14,938	7,619	7,487
Claims Payable	-	50,749	72,446	50,614	55,017	8,255
Accrued expenses and other	27,442	5,078	10,712	1,296	1,334	1,376
Net cash provided by operating activities:	(540,705)	(2,009,429)	(245,912)	944,469	835,885	815,043
Cash flows from investing activities						
Acquisition of land, buildings and equipment	(1,335,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)
Restricted Assets Released for Capital	-	-	-	-	-	-
Decrease (increase) in assets limited as to use	(124,295)	(70,571)	(584,088)	(124,469)	(65,885)	4,957
Net cash provided by (used in) investing activities:	(1,459,295)	(90,571)	(604,088)	(144,469)	(85,885)	(15,043)
Cash flows from financing activities						
Restricted contributions received for specific purpose	-	-	-	-	-	-
Transfer from affiliate	-	-	-	-	-	-
Proceeds from line of credit	2,000,000	2,400,000	850,000	(800,000)	(750,000)	(800,000)
Proceeds/(Repayment) of long-term debt	-	-	-	-	-	-
Partnership Contributions/(Distributions)	-	-	-	-	-	-
Payment of deferred financing costs						
Net cash (used in) provided by financing activities:	2,000,000	2,400,000	850,000	(800,000)	(750,000)	(800,000)
Change in cash and cash equivalents:	-	300,000	(0)	0	(0)	0
Cash and cash equivalents at beginning of year:	0	-	300,000	300,000	300,000	300,000
Cash and cash equivalents at end of year:	-	300,000	300,000	300,000	300,000	300,000
	-	(0)	(0)	(0)	(0)	0

Fairfax PACE
Annual Projections

KEY FINANCIAL RATIOS

	Startup	Year 1	Year 2	Year 3	Year 4	Year 5
Member Months		323	1,048	1,488	1,488	1,488
# of Enrollees		54	118	124	124	124
Margin Ratios						
Operating Margin		-105.1%	-4.5%	8.3%	6.9%	6.9%
Operating Income (Excluding Interest Income & Expense)		-97.2%	-0.9%	10.9%	9.1%	8.7%
Excess Margin		-105.1%	-4.5%	8.3%	6.9%	6.9%
Earnings Before Interest, Depreciation, & Amortization (in 000's)		$ (1,872)	$ 34	$ 1,170	$ 1,006	$ 995
As % of Capitation Revenues		-92.7%	0.5%	11.9%	10.0%	9.6%
Liquidity Ratios						
Days Cash on Hand		44.6	56.7	49.4	49.9	48.4
Days in Account Receivable		30.56	20.48	15.21	15.21	15.21
Required Reserves (in 000's)		$ 471	$ 1,064	$ 1,176	$ 1,225	$ 1,262
Reserve Amount (in 000's)		$ 195	$ 779	$ 903	$ 969	$ 964
Adequacy %		41%	73%	77%	79%	76%
Capital Structure Ratios						
Debt Service Coverage Ratio						
Unrestricted Cash & Investements to Long Term Debt		N/A	N/A	N/A	N/A	N/A
Capital Investment	$1,335,000					
Capital Additions		20,000	20,000	20,000	20,000	20,000
Funding Sources (in 000's)						
Equity Contributions	-	-	-	-	-	-
Debt Financing	-					
Line of Credit	2,000	2,400	850	-	-	-
Contributions/Grants	-	-	-	-	-	-
Operating Ratios						
Revenue PMM		$ 6,249.64	$ 6,427.51	$ 6,584.59	$ 6,767.06	$ 6,954.37
Member Costs PMM		6,358.06	4,531.27	4,418.89	4,665.75	4,818.51
Sub-Total		(108.42)	1,896.24	2,165.70	2,101.31	2,135.86
General & Administrative PMM		6,461.14	2,184.53	1,622.38	1,634.96	1,652.83
Interest Income PMM		-	-	-	-	-
Non-Operating RevenuE/(Expense) PMM		-	-	-	-	-
Total Revenue/(Cost) PMM:		$ (6,569.56)	$ (288.29)	$ 543.32	$ 466.35	$ 483.02
Total F.T.E.'s		26.1	34.4	38.8	38.8	38.8
Participants Per F.T.E.		2.1	3.4	3.2	3.2	3.2
Hospital Days/1000		3,400	3,200	3,000	2,700	2,400
Nursing Home Utilization as % of Cap Days		1.0%	3.0%	4.0%	6.0%	7.0%
Assisted Living Utilization as % of Cap Days		2.0%	3.0%	4.0%	5.0%	5.0%

Appendix I

Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies

April 7, 2008

NOTE TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies

In accordance with section 1853(b)(1) of the Social Security Act (the Act), we are notifying you of the annual Medicare Advantage (MA) capitation rate for each MA payment area for 2009, and the risk and other factors to be used in adjusting such rates. Attached is a spreadsheet containing the capitation rate tables for CY 2009. Also included is a spreadsheet which shows the statutory component of the regional benchmarks. The rates are posted on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/ under Ratebooks and Supporting Data.

Attachment I shows the final estimates of the increase in the National Per Capita MA Growth Percentage for 2009. As discussed in Attachment I, the final estimate of the increase in the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 4.24 percent. These growth rates will be used as the minimum update percentage in calculating the 2009 rates, except for the ESRD State rates, which are subject to a 2 percent minimum increase under Section 1853(a)(1)(H). The county fee-for-service (FFS) rates for 2009 were rebased. Under section 1853(c)(1) of the Act, MA capitation rates in 2009 will be based on the higher of the county FFS per capita amount or a minimum percent increase over the 2008 rate.

Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the National Per Capita MA Growth Percentage.

Section 1853(b)(4) of the Act requires CMS to release county-specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2006 is being posted on the above website at this time as well.

We received comments from 30 organizations in response to CMS' request for comments on the Advance Notice of Methodological Changes for CY 2009 MA Capitation Rates and Part D Payment Policies (Advance Notice), published on February 22, 2008. Six comments were from Associations, 23 comments were from plans, and one comment was from the Congress. Attachment III summarizes key policy changes from the approaches proposed in the Advance Notice , the key policies adopted as proposed in the Advance Notice, and then presents responses to comments on Part C and Part D issues in the Advance Notice. Attachment IV contains tables with the 2009 CMS-HCC risk adjustment factors, Part D benefit parameters, and other information. The CMS-HCC factors are also available in Excel files on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage.

Questions can be directed to:

Paul Spitalnic (410-786-2328) for Attachments I and II

Anne Hornsby (410) 786-1181 and Rebecca Paul at (410) 786-0852 for Attachments III and IV.

/ s /
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/ s /
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Attachments

Attachment I. Final Estimate of the Increase in the National Per Capita MA Growth Percentages for 2009

The first table below shows the National Per Capita MA Growth Percentages (NPCMAGP) used to determine the minimum update percentages for 2009. Adjustments of 0.22 percent, 2.07 percent, -11.69 percent and 0.48 percent for aged, disabled, ESRD, and combined aged and disabled, respectively, are included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled increase is used in the development of the ratebook.

The second table below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2008 and 2009. In addition, for 2009, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2009. These data were furnished by the Office of the Actuary.

Increase in the National Per Capita MA Growth Percentages for 2009

	Prior Increases	Current Increases			NPCMAGP for 2009 With Sec.1853(c)(6)(C) adjustment[1]
	2003 to 2008	2003 to 2008	2008 to 2009	2003 to 2009	
Aged	33.78%	34.07%	3.66%	38.97%	3.88%
Disabled	38.10%	40.96%	4.20%	46.87%	6.35%
ESRD[2]	28.99%	13.91%	1.34%	15.44%	- 10.51%[3]
Aged+Disabled	34.24%	34.89%	3.74%	39.94%	4.24%

[1]Current increases for 2003 to 2009 divided by the prior increases for 2003 to 2008.

[2]Starting in 2008, increases for ESRD reflect an estimate of the increase for dialysis-only beneficiaries.

[3]The NPCMAGP for ESRD for 2009 will be the minimum 2 percent increase.

Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2008 and 2009

	2008	2009	Change	2009 non-ESRD
Part A Benefits	36.71	37.94	3.35%	36.35
Part B Benefits[4]	105.69	97.97	- 7.30%	92.30
Total Medicare	142.40	135.91	- 4.56%	128.65

[4]Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for current law MSA plans for 2009 is $10,500. For MSA demonstration plans, the 2009 minimum deductible amount is $2,200, the maximum out-of-pocket amount is $10,500, and the minimum difference between the deductible and deposit is $1,000.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentages. Attached is a table that compares the published United States Per Capita Costs (USPCC) with current estimates for 2000 to 2009. In addition, this table shows the current projections of the USPCCs through 2011. We are also providing an attached set of tables that summarizes many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2000 through 2011.

All of the information provided in this enclosure applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

None of the data presented here pertain to the Medicare prescription drug benefit.

Comparison of Current Estimates of the USPCC with Published Estimates

PART A:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$263.29	$286.18	1.087	$218.80	$230.48	1.053	$257.32	$278.61	1.083
2001[1]	$283.70	$288.62	1.017	$234.62	$235.50	1.004	$276.94	$281.25	1.016
2001[2]	$283.70	$298.43	1.052	$234.62	$242.00	1.031	$276.94	$290.59	1.049
2002	$297.13	$294.46	0.991	$248.90	$242.06	0.973	$290.30	$287.10	0.989
2003	$304.89	$290.50	0.953	$254.01	$234.89	0.925	$297.41	$282.50	0.950
2004	$321.69	$326.78	1.016	$268.45	$271.69	1.012	$313.59	$318.43	1.015
2005	$344.77	$348.28	1.010	$288.32	$291.45	1.011	$335.90	$339.49	1.011
2006	$354.98	$351.38	0.990	$302.34	$295.15	0.976	$346.55	$342.67	0.989
2007	$369.31	$370.34	1.003	$326.21	$318.17	0.975	$362.38	$362.06	0.999
2008	$395.22	$385.61	0.976	$356.44	$344.31	0.966	$389.02	$379.02	0.974
2009	$414.22	$414.22	1.000	$378.40	$378.40	1.000	$408.50	$408.50	1.000
2010	$430.77			$395.77			$425.13		
2011	$445.76			$412.87			$440.46		

PART B:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$199.17	$218.78	1.098	$183.62	$195.91	1.067	$197.24	$216.03	1.095
2001[1]	$219.73	$217.57	0.990	$206.93	$191.99	0.928	$218.10	$214.32	0.983
2001[2]	$219.73	$223.83	1.019	$206.93	$198.69	0.960	$218.10	$220.63	1.012
2002	$233.03	$244.17	1.048	$226.37	$218.23	0.964	$232.16	$240.76	1.037
2003	$250.81	$232.24	0.926	$246.76	$211.58	0.857	$250.26	$229.47	0.917
2004	$276.49	$263.39	0.953	$274.60	$252.74	0.920	$276.22	$261.89	0.948
2005	$296.08	$281.90	0.952	$292.35	$272.79	0.933	$295.54	$280.58	0.949
2006	$318.61	$311.28	0.977	$312.22	$316.82	1.015	$317.66	$312.09	0.982
2007	$332.84	$334.02	1.004	$329.40	$343.76	1.044	$332.32	$335.47	1.009
2008	$349.79	$354.44	1.013	$349.43	$343.26	0.982	$349.74	$352.75	1.009
2009	$358.03	$358.03	1.000	$357.10	$357.10	1.000	$357.89	$357.89	1.000
2010	$370.01			$371.74			$370.27		
2011	$381.97			$386.31			$382.63		

PART A & PART B:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$462.46	$504.96	1.092	$402.42	$426.39	1.060	$454.56	$494.64	1.088
2001[1]	$503.43	$506.19	1.005	$441.55	$427.49	0.968	$495.04	$495.57	1.001
2001[2]	$503.43	$522.26	1.037	$441.55	$440.69	0.998	$495.04	$511.22	1.033
2002	$530.16	$538.63	1.016	$475.27	$460.29	0.968	$522.46	$527.86	1.010
2003	$555.70	$522.74	0.941	$500.77	$446.47	0.892	$547.67	$511.97	0.935
2004	$598.18	$590.17	0.987	$543.05	$524.43	0.966	$589.81	$580.32	0.984
2005	$640.85	$630.18	0.983	$580.67	$564.24	0.972	$631.44	$620.07	0.982
2006	$673.59	$662.66	0.984	$614.56	$611.97	0.996	$664.21	$654.76	0.986
2007	$702.15	$704.36	1.003	$655.61	$661.93	1.010	$694.70	$697.53	1.004
2008	$745.01	$740.05	0.993	$705.87	$687.57	0.974	$738.76	$731.77	0.991
2009	$772.25	$772.25	1.000	$735.50	$735.50	1.000	$766.39	$766.39	1.000
2010	$800.78			$767.51			$795.40		
2011	$827.73			$799.18			$823.09		

[1]Applies to M+C ratebook for January to February, 2001
[2]Applies to M+C ratebook for March to December, 2001

Comparison of Current Estimates of the USPCC with Published Estimates- continued

PART A:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,311.44	$1,443.13	1.100
2001[1]	$1,424.11	$1,541.76	1.083
2001[2]	$1,424.11	$1,597.34	1.122
2002	$1,459.75	$1,435.62	0.983
2003	$1,570.85	$1,596.58	1.016
2004	$1,682.53	$1,685.25	1.002
2005	$1,589.31	$1,759.90	1.107
2006	$1,635.76	$1,717.97	1.050
2007	$1,687.04	$1,874.54	1.111
2008	$1,812.40	$1,855.03	1.024
2009	$1,911.06	$1,911.06	1.000
2010	$1,996.18		
2011	$2,077.10		

PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,676.80	$2,436.13	1.453
2001[1]	$1,880.19	$1,875.57	0.998
2001[2]	$1,880.19	$1,921.53	1.022
2002	$1,995.37	$2,014.79	1.010
2003	$2,021.40	$1,847.53	0.914
2004	$2,161.10	$2,552.18	1.181
2005	$2,304.98	$2,739.99	1.189
2006	$2,257.38	$2,454.98	1.088
2007	$2,308.31	$2,470.81	1.070
2008	$2,279.51	$2,773.04	1.217
2009	$2,235.70	$2,235.70	1.000
2010	$2,250.59		
2011	$2,269.06		

PART A & PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$2,988.24	$3,879.26	1.298
2001[1]	$3,304.30	$3,417.33	1.034
2001[2]	$3,304.30	$3,518.87	1.065
2002	$3,455.12	$3,450.41	0.999
2003	$3,592.25	$3,444.11	0.959
2004	$3,843.63	$4,237.43	1.102
2005	$3,894.29	$4,499.89	1.156
2006	$3,893.14	$4,172.95	1.072
2007	$3,995.35	$4,345.35	1.088
2008	$4,091.91	$4,628.07	1.131
2009	$4,146.77	$4,146.77	1.000
2010	$4,246.77		
2011	$4,346.16		

[1]Applies to M+C ratebook for January to February, 2001
[2]Applies to M+C ratebook for March to December, 2001

Summary of Key Projections Under Present Law[1]

Part A

Year	Calendar Year CPI Percent Increase	Fiscal Year PPS Update Factor	FY Part A Total Reimbursement (Incurred)
2000	3.5	1.1	-0.8
2001	2.7	3.4	7.9
2002	1.4	2.8	7.7
2003	2.2	3.0	3.9
2004	2.6	3.4	8.5
2005	3.5	3.3	8.9
2006	3.2	3.7	5.8
2007	2.8	3.4	6.5
2008	2.8	3.3	8.3
2009	2.5	2.8	7.9
2010	2.8	1.4	6.4
2011	2.8	2.8	6.0

Part B[2]

Calendar Year	Physician Fee Schedule		Part B Hospital	Total
	Fees	Residual[3]		
2000	5.5	3.6	-0.8	10.4
2001	4.8	4.1	12.5	9.7
2002	–4.8	6.1	-1.4	6.1
2003	1.7	4.5	5.4	6.9
2004	1.5	5.9	9.9	9.7
2005	1.5	3.3	8.3	6.8
2006	0.2	4.7	4.5	5.9
2007	0.0	4.0	2.2	3.3
2008	–4.6	5.2	4.7	3.9
2009	–10.4	6.6	6.5	1.7
2010	–5.5	3.2	7.0	2.9
2011	–5.3	3.2	6.6	2.9

[1]Percent change over prior year.
[2]Percent change in charges per Aged Part B enrollee.
[3]Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

Medicare Enrollment Projections Under Present Law (In Millions)

Non-ESRD

Calendar Year	Part A		Part B	
	Aged	Disabled	Aged	Disabled
2000	33.700	5.222	32.421	4.590
2001	33.904	5.416	32.582	4.747
2002	34.080	5.619	32.713	4.915
2003	34.427	5.929	33.027	5.187
2004	34.837	6.249	33.282	5.458
2005	35.244	6.574	33.584	5.747
2006	35.781	6.820	33.960	5.975
2007	36.361	6.965	34.363	6.128
2008	37.032	7.042	34.927	6.197
2009	37.793	7.178	35.557	6.318
2010	38.503	7.398	36.131	6.496
2011	39.408	7.570	36.833	6.646

ESRD Part A

Calendar Year	Part A			
	Aged	Disabled	299I[1]	Total
2000	0.136	0.109	0.088	0.333
2001	0.144	0.115	0.091	0.349
2002	0.151	0.120	0.094	0.366
2003	0.160	0.126	0.096	0.383
2004	0.167	0.132	0.100	0.399
2005	0.174	0.137	0.104	0.415
2006	0.182	0.141	0.107	0.430
2007	0.190	0.143	0.110	0.443
2008	0.199	0.144	0.113	0.455
2009	0.206	0.146	0.116	0.468
2010	0.213	0.149	0.118	0.480
2011	0.219	0.152	0.120	0.491

ESRD Part B

Calendar Year	Part B			
	Aged	Disabled	299I	Total
2000	0.138	0.104	0.082	0.324
2001	0.145	0.110	0.084	0.338
2002	0.153	0.114	0.087	0.354
2003	0.161	0.120	0.088	0.370
2004	0.168	0.125	0.089	0.382
2005	0.175	0.130	0.092	0.396
2006	0.183	0.133	0.095	0.411
2007	0.190	0.135	0.097	0.422
2008	0.198	0.135	0.100	0.433
2009	0.206	0.137	0.102	0.444
2010	0.212	0.140	0.103	0.455
2011	0.218	0.143	0.105	0.466

[1] Individuals who qualify for Medicare based on ESRD only.

Part A Projections Under Present Law [1]

Calendar Year	Inpatient Hospital		SNF		Home Health		Managed Care		Hospice: Total Reimbursement (in Millions)	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
2000	2,218.26	2,385.85	310.23	104.90	99.05	70.38	593.36	269.74	2,772	146
2001	2,406.91	2,595.76	376.02	129.04	121.53	64.75	571.77	255.43	3,575	188
2002	2,578.76	2,780.67	411.58	145.08	130.36	69.82	523.26	227.72	4,391	231
2003	2,670.88	2,863.47	420.10	149.83	132.99	72.01	522.57	218.64	5,428	286
2004	2,776.44	3,007.09	469.84	173.01	143.45	78.03	569.12	236.84	6,506	342
2005	2,886.98	3,141.22	513.73	193.18	151.58	82.66	675.62	300.03	7,612	401
2006	2,837.70	3,134.52	542.50	206.19	151.98	83.23	823.75	474.01	8,748	460
2007	2,829.10	3,213.58	565.07	221.10	154.92	87.39	984.40	666.45	9,453	498
2008	2,939.56	3,435.57	583.27	235.54	154.64	89.99	1,175.32	805.09	10,113	532
2009	3,029.56	3,601.65	601.50	248.51	155.54	92.45	1,300.70	897.73	10,854	571
2010	3,109.61	3,728.42	619.02	259.56	156.74	94.37	1,405.86	975.24	11,658	614
2011	3,184.88	3,861.11	634.19	271.16	156.90	96.05	1,499.60	1,043.05	12,510	658

[1]Average reimbursement per enrollee on an incurred basis, except where noted.

Part B Projections Under Present Law[1]

Calendar Year	Physician Fee Schedule		Part B Hospital		Durable Medical Equipment	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	1,003.19	951.69	238.98	290.69	118.54	184.47
2001	1,131.47	1,064.17	326.94	400.13	137.14	215.29
2002	1,177.46	1,109.73	333.67	423.49	158.40	261.50
2003	1,263.13	1,190.84	378.19	470.64	182.20	302.52
2004	1,393.46	1,311.26	429.01	545.24	180.98	301.14
2005	1,452.56	1,355.63	472.86	584.41	181.59	304.17
2006	1,457.68	1,335.63	489.78	599.35	185.65	314.41
2007	1,430.16	1,327.52	486.21	613.63	181.03	315.26
2008	1,371.02	1,295.41	496.09	639.55	185.69	333.65
2009	1,279.68	1,222.91	523.40	682.54	179.85	328.19
2010	1,230.21	1,184.36	556.97	731.97	185.64	342.21
2011	1,184.41	1,148.13	591.38	782.77	191.75	357.18

Calendar Year	Carrier Lab		Other Carrier		Intermediary Lab	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	58.89	61.22	201.38	195.17	46.25	59.30
2001	64.86	66.15	239.97	231.14	47.73	64.78
2002	70.96	74.14	286.95	281.69	55.38	74.69
2003	76.42	79.72	337.18	349.92	60.27	80.00
2004	82.37	86.53	362.42	395.20	65.27	88.18
2005	86.79	91.26	371.40	422.84	67.49	91.92
2006	89.80	95.03	376.42	387.94	67.83	92.96
2007	92.25	105.97	381.02	397.92	63.98	90.82
2008	94.33	113.32	413.89	446.22	62.72	90.94
2009	100.76	122.32	452.17	489.48	64.52	94.60
2010	106.57	130.27	492.00	532.51	66.92	98.85
2011	112.57	138.55	535.41	580.30	69.81	103.84

Calendar Year	Other Intermediary		Home Health		Managed Care	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	117.91	108.13	129.45	99.19	531.83	221.42
2001	138.59	114.61	125.20	104.59	498.03	189.91
2002	173.74	143.90	131.98	110.78	494.67	205.08
2003	179.80	138.02	139.32	117.10	481.20	199.56
2004	205.83	165.80	159.56	133.66	537.12	233.86
2005	227.89	178.59	183.06	154.29	624.54	291.73
2006	225.97	187.06	206.98	176.21	836.07	531.56
2007	222.49	187.29	241.42	206.61	1,017.79	683.90
2008	226.83	198.19	257.46	225.22	1,216.35	825.41
2009	225.11	199.81	268.08	238.03	1,333.73	884.49
2010	233.98	210.00	275.19	247.02	1,430.58	956.74
2011	243.47	220.94	276.61	251.43	1,523.40	1,024.61

[1]Average reimbursement per enrollee on an incurred basis.

Claims Processing Costs as a Fraction of Benefits

Calendar Year	Part A	Part B
2000	0.002195	0.014790
2001	0.001862	0.013223
2002	0.001496	0.011708
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001515	0.009540
2006	0.001245	0.007126
2007	0.000968	0.006067
2008	0.000968	0.006067
2009	0.000968	0.006067
2010	0.000968	0.006067
2011	0.000968	0.006067

Approximate Calculation of the USPCC and the National MA Growth Percentage for Aged Beneficiaries

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A:
The Part A USPCC for aged beneficiaries can be approximated by using the assumptions in the tables titled "Part A Projections Under Present Law" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts for the aged over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis. The last step is to multiply by .97612 to get the USPCC for the aged non-ESRD. This final factor of .97612 is the relationship between the total and non-ESRD per capita reimbursements in 2009. This factor does not necessarily hold in any other year.

Part B:
The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections Under Present Law" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts for the aged over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses and divide by 12 to put this amount on a monthly basis. Then multiply by .96457 to get the USPCC for the aged non-ESRD.

The National Per Capita MA Growth Percentage:

The National Per Capita MA Growth Percentage for 2009 (before adjustment for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2009 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2008.

Attachment III. Responses to Public Comments

Key Policy Changes from the Advance Notice

Attachment I provides the final estimates of the National MA Growth Percentages (growth trends) and information on deductibles for MSA standard and demonstration plans, and on the maximum out-of-pocket amount for MSA demonstrations plans.

Attachment III, Section E announces the policy decision on the MA coding intensity adjustment for 2009.

Attachment III, Section F provides information on upcoming audit activities.

Attachment III, Section G announces that the CMS is unable to determine for CY 2009 whether an adjustment other than zero to the FFS rates is appropriate to reflect the cost of services obtained by MA enrollees at VA and DoD facilities.

Attachment III, Section I announces that CMS is still preparing the final rule concerning the reporting of drug costs for Part D sponsors that contract with PBMs, and discusses Part D sponsors' options for pricing.

Attachment III, Section J announces that the proposal in the Advance Notice on calculation of the low-income benchmark premium amount is replaced by the approach announced in the final rule CMS-4133-F, titled "Modification to the Weighting Methodology Used to Calculate the Low-income Benchmark Amount," published on April 3, 2008.

As in past years, policies proposed in the Advance Notice that are not modified or retracted in the Rate Announcement become effective in the upcoming payment year, as set forth in the Advance Notice. Clarifications in the Announcement supersede materials in the Advance Notice.

Key Policies Adopted as Proposed in the Advance Notice

Recalibration of the CMS-HCC model. In 2009, CMS will implement an updated version of the aged-disabled CMS-HCC risk adjustment model, including community, institutional, and new enrollee segments of the model. See Section B below for comments and responses regarding the recalibrated model. See Attachment IV, Tables 1, 2, and 3 for the final 2009 model coefficients.

Recalibrated frailty factors. CMS will implement recalibrated frailty factors for CY 2009. See Attachment IV, Table 4 for the final factors.

Frailty Adjustment Transition for PACE organizations. Frailty adjustment factors will be applied to payment to PACE organizations using the transition schedule published in the 2008 Announcement (published April 2, 2007). PACE frailty scores for payment year 2009 will be calculated at a blend of 70% of the frailty factors in use prior to 2008 and 30% of the recalibrated frailty factors implemented in 2009.

Frailty Adjustment Transition for Certain Demonstrations. Frailty adjustment factors will be applied to payment to the following MA plan types using the phase-out schedule published in the 2008 Announcement (published April 2, 2007): Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans. The phase out schedule for 2009 is 50% of the pre-2008 frailty factors.

Normalization Factors. Normalization factors for 2009 are as follows:

- The final 2009 normalization factor for the aged-disabled model is 1.030.
- The final 2009 normalization factor for the ESRD dialysis model is 1.019.
- The final 2009 normalization factor to be applied to the risk scores of enrollees in functioning graft status is 1.058.
- The final 2009 normalization factor for the RxHCC model is 1.085.

Budget Neutrality. For 2009, 25 percent of the BN factor will be applied to the risk rates.

Medicare as Secondary Payer (MSP) Adjustment Factor for Aged & Disabled Enrollees. CMS has recalculated the MSP adjuster for working aged and working disabled beneficiaries. The adjuster will be 0.174 in the 2009 payment year.

ESRD Bidding and Payment. For 2009, CMS will continue the policy of excluding costs for ESRD enrollees in the plan A/B bid.

For payment year 2009, CMS' payments for ESRD dialysis and transplant enrollees will be based on State rates calculated using a blend of 50% of the old State ratebook (in use through 2007) and 50% of the revised State ratebook (implemented in 2008).

For 2009 CMS will continue to use the functioning graft coefficients published in the April 7, 2007 Advance Notice for 2008, when the ESRD dialysis model was last recalibrated. (See above for the 2009 normalization factor to be used with the functioning graft risk scores.)

Regional Plan Stabilization Fund. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 – enacted December 18, 2007 – delayed Stabilization Fund payments until January 1, 2013.

Continuation of Clinical Trial Policy. In 2009, we will continue the policy of paying on a fee-for-service basis for clinical trial items and services provided to MA plan members that are covered under the relevant National Coverage Determinations on clinical trials.

Reporting of Medicaid Status for Part C Payment. In CY 2009, CMS will complete the transition to using the MMA Medicare/Medicaid Dual Eligible monthly submission file (MMA State files) as the main source of Medicaid status for Part C plan payments. The data sources for the assignment of Medicaid status can be found in Attachment IV, Table 5.

Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment. Starting with payment year 2009, RAPS will only accept valid ICD-9-CM codes for two fiscal years -- the fiscal year that begins prior to the payment year and the fiscal year that begins during the payment year -- for the CMS-HCC, ESRD, and RxHCC risk adjustment models. For example, for diagnoses codes to be used

in 2009 final payment, i.e., for diagnoses from service dates between January 1, 2008 and December 31, 2008, RAPS will only accept codes that are valid for Fiscal Year 2008 and Fiscal Year 2009. See Attachment IV, Table 6 for the acceptable codes.

Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2009. In accordance with section 1860D-2(b) of the Social Security Act (the Act), CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. See Attachment IV, Table 7 for the 2009 updated Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy.

Calculation of the Part D National Average Monthly Bid Amount. CMS will complete the transition to the weighted average method based on actual plan enrollments in 2009. Thus for contract year 2009, 100% of the national average monthly bid amount will be based on the enrollment-weighted average.

Coordination of Benefits (COB) User Fees. Upon review of the anticipated costs of COB activities in 2009, the Part D COB user fee will increase to $2.52 per enrollee per year for contract year 2009. This COB user fee will be collected at a rate of $0.28 per enrollee per month from January to September (for an annual rate of $0.21 per enrollee per month) for a total user fee of $2.52 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2009 bids.

Budget Neutrality Offsets for Reinsurance Payment Demonstration Plans in 2009. The budget neutrality offsets applied to the capitated reinsurance payments for flexible capitated, fixed capitated, and Medicare Advantage rebate option plans will remain at $10.00 per member per year for contract year 2009.

Payment Reconciliation. The 2009 risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2008. The risk percentages for the first and second thresholds remain at 5% and 10% of the target amount respectively for 2009. The payment adjustments for the first and second corridors are 50% and 80% respectively.

As in past years, policies proposed in the Advance Notice that are not modified or retracted in the Rate Announcement become effective in the upcoming payment year, as set forth in the Advance Notice. Clarifications in the Announcement supersede materials in the Advance Notice.

Section A. Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2009

As mentioned in Attachment I, the final estimate of the 2009 MA growth trend for combined aged and disabled beneficiaries is 4.24 percent, which is a little lower than the preliminary estimate of 4.8 percent announced February 22, 2008 in the Advance Notice. The President's Budget baseline was used for the preliminary estimate, and the 2008 Trustees Report baseline was used for the final estimate. The primary reason for the lower final estimate is that cash expenditure data for the remainder of 2007 was available which indicated that the actual expenditures for 2007 were lower than previously estimated.

The manner in which the Tax Relief and Health Care Act (TRHCA) of 2006 and the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 structured the physician fee schedule increase affects both the adjustment to the 2008 growth rate and the 2009 trend as compared to the 2009 trend reported in the 2007 Trustees Report. About 1 percentage point of the 1.9 percent increase in the 2008 trend is due to legislative changes in the physician fee schedule update, because the previously expected -10 percent adjustment for 2008 was eliminated for half of the year and replaced with a 0.5 percent update. For the second half of the 2008, the update will revert to the current law update of -10 percent, as required by the MMSEA of 2007. Hence, the average for the year is approximately a -5 percent update. The -5 percent update compared to the previously expected -10 percent update increases the overall USPCC growth rate for 2008 by about 1 percent.

However, this revision to the prior 2008 estimate of about a 1 percent increase is offset by a reduction in the 2009 trend change. That is because, under the MMSEA, the 2008 increase has no effect on the calculation of the 2009 physician fee schedule update. As a result, the current law baseline for 2009 reflects a -10 percent update for physician fees. The net impact on the overall 2009 USPCC of this -10 percent update compared to the -5 percent for 2009 as reported last year is about a 1 percent decrease in the trend.

Comment: One commenter believes that the proposed 2009 trend change in the Advance Notice of 3.4% is too low and does not reflect the underlying increases in Medicare health care costs. This commenter feels that CMS should increase the 2009 trend change in the final notice to at least 4.5 percent to be aligned with other CMS estimates of Medicare growth. In addition, this commenter was concerned with the downward adjustments in the growth percentage for 2005 and 2007 and recommended that CMS increase these adjustments to previous years' trend changes and provide a detailed explanation for these proposed changes. Finally, the same commenter recommended that CMS recalculate the estimate of 100% FFS costs for previous years to account for increased Medicare physician payments and trend forward to the 2009 rates.

Response. By law, CMS must release the national MA growth percentage for the upcoming year by the first Monday in April. In years when legislative changes to the physician fee schedule updates are passed after April, such changes are not incorporated into the MA growth trend until the following year, when they are reflected as adjustments to the prior years' estimates. The Tax Relief & Health Care Act (THRCA) of 2006 and the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 explicitly limited the increased physician fee schedule updates—for 2007 and for the first half of 2008, respectively, to specific time periods. Moreover, the TRHCA required that the physician fee schedule update for 2008 must be calculated as if the 2007 increase did not occur. Similarly, the MMSEA requires that the physician fee schedule update for the last six months of 2008 and 2009 must be calculated as if the increase for the first six months of 2008 did not occur. As a result, in 2007 and 2008, OACT had to estimate underlying trends for CYs 2008 and 2009, respectively, based on current law updates of approximately -10%.

Regarding the commenter's question about prior years' estimates, the additional adjustments to the 2004 to 2006 growth rates are fairly insignificant and for the three years combined are slightly positive. Since the Medicare growth rates are tabulated on an incurred basis, it can take several years before all bills for a given year are tabulated through the claims history file. This is

why we can still see small changes for years back to 2004. The latest estimates for 2007 were based on incurred data reported through June of 2007. Hence, the claims history for 2007 is relatively incomplete. CMS has cash data through December 2007 from the U.S. Treasury, which indicates that outlays for 2007 were lower than expected. Therefore, the expected increase for 2007 was lowered. As more incurred data is received for 2007, adjustments will be made to account for the actual 2007 trend rates as allowed by law in future payment updates.

Regarding the commenter's recommendation that CMS recalculate the estimate of 100% FFS costs for previous years to account for increased Medicare physician payments and trend forward to the 2009 rates, this is not necessary. The law already allows for adjustments to the growth percentage for prior years' over/underestimates. Therefore, increased payments due to the prior legislative physician updates are already accounted for. In addition, the historical data which is used for calculating the geographic indices for the 100% FFS costs also reflect all prior legislative changes.

Section B. Recalibration of the CMS-HCC Model

Comment. One commenter stated that recalibrating on a biannual basis adds significant uncertainty for MA organizations because of the complexity of estimating the impact of recalibration as they engage in the bid development process and consider strategies for continuing to provide comprehensive and stable benefit packages to enrollees. The commenter recommended that CMS recalibrate the model once every three years, instead of biannually, in order to provide MA organizations with more predictability, while also ensuring the risk adjustment model continues to be based upon regularly updated data. Another commenter was concerned about significant year-to-year variations in MA payments accompanying the recalibration of the CMS-HCC risk adjustment model, and requested that CMS explore opportunities to reduce such variations. In particular, this commenter was concerned that plans in certain geographic areas not be disadvantaged over other plans in other geographic areas.

Response. CMS' policy goal is to recalibrate every two years to strike a balance between updating the model to reflect recent shifts in average relative expenditures among disease groups and reducing the burden of annual model changes. Recalibrating every three instead of every two years could generate more significant shifts in the relative cost factors for each HCC grouping, which could increase the relative level of changes in payments and the degree of uncertainty for the industry. Moreover, CMS seeks to align recalibration of the CMS-HCC model with rebasing of the FFS rates.

In terms of the commenter's request that CMS consider ways to reduce differential geographic impacts, CMS recalibrates the CMS-HCC model using actual FFS diagnoses and claims expenditures. We are not clear what options we could explore to reduce actual geographic variation.

Comment. Two commenters requested that CMS post to the Health Plan Management System (HPMS) as soon as possible the recalibrated risk scores for plans. The commenters noted that this information is critical in order to develop accurate bids. One commenter also noted that it is

difficult to comment on a new model without knowledge of how that model could impact their plan.

Response. Plan-specific recalibrated risk scores will be available through HPMS the week of April 7, 2008, in conjunction with the final bid instructions. In addition, the 2009 CMS-HCC model software reflecting the model recalibrated risk factors was posted March 7, 2008 on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

Comment. One commenter requested that CMS publish frequency tables that show the estimated number of beneficiaries who fall into each HCC category under the existing and recalibrated models (e.g., the percent of members with HCC1 in 2004 and also in 2005) in the 2009 Rate Announcement, and in future Advance Notices. The commenter indicated that this information will assist plans in evaluating the impact of the recalibration as they develop their bids.

Response. This information is available through analysis of the 5 percent Standard Analytic File (SAF). CMS provides the CMS-HCC model software, as mentioned above, to facilitate the analysis described by the commenter.

Comment. One commenter expressed concern that the recalibrated risk factors could result in plan risk score reductions that would drop risk adjusted payments below the level of budget neutrality. The commenter requested that CMS publish the math and supporting documentation for the recalibration of the CMS-HCC coefficients.

Response. In terms of the relationship of recalibrated model factors to the budget neutrality factor, CMS determined the budget neutrality factor for 2009 using the recalibrated risk scores for each plan. Specifically, the BN factor is calculated as the estimated difference between payments to MA organizations at 100 percent of the demographic rates and payments at 100 percent of the risk rates. The size of the total BN factor is determined by the difference in aggregate payments made to MA organizations under the recalibrated risk model and aggregate payments made under the demographic model. Therefore, the effect of the recalibrated model is taken into account when the BN factor is calculated. As we noted in the Advance Notice, for 2009, 25 percent of the BN factor is applied to the risk rates that have been released with this Announcement.

Comment. One commenter expressed concern that their preliminary estimates of the impact of the recalibrated CMS-HCC model leads to a reduction in risk scores.

Response. . At the aggregate level, model recalibration has a neutral effect on the MA risk scores. When we recalibrate, the relative payment weights (risk factors) in the model can change, potentially affecting plan-specific average risk scores. The plan-specific impact will depend on the disease profile of the beneficiaries enrolled in the plan.

Section C. Normalization Factors

Comment. One commenter expressed appreciation that CMS released preliminary estimates of the normalization factors. The commenter also expressed concern that the CMS-HCC factor

represents a 3 percent reduction to risk scores, which will offset any increase in the MA capitation rates. The commenter recommended that CMS reduce the normalization factor and continue to do so as the BN factor is phased-out because continuing high negative adjustments will negatively impact MA payments as budget neutral risk-adjustment is phased out.

Response. CMS is required by the Deficit Reduction Act of 2005 to phase-out the implementation of budget neutral risk-adjusted payments (i.e., budget neutral to payments based on 100 percent of the demographic rates). Application of the normalization factors addresses an unrelated issue, which is that CMS must correct for population and coding changes between the data years used in calculating the model relative factors (the "denominator year") and the payment year. CMS cannot phase-out application of normalization factors because there will always be a lag between denominator and payment years.

Comment. One commenter requested additional information regarding how the 2009 normalization factor for the RxHCC model was determined because the factor of 1.085 appears to be a significant recalibration of Rx risk scores. The commenter requested additional explanation of how the annual trend is calculated and how it is applied for the two years between the calculation of actual average Part D risk score and the payment year (2007-2009). In addition, the commenter asked what prescription drug data was used before Part D began in 2006.

Response. The Part D normalization factor was 1.065 for 2008, and will be 1.085 for 2009. To calculate the 2009 Part D normalization factor, which will adjust for coding trends from the calibration year (2004) to the payment year (2009), we first obtained the actual trend in Part D risk scores by using the actual 2007 average Part D risk score for all potential Part D enrollees. We then projected the trend from 2007 to 2009 using an annual trend calculated on five years of risk score data (2003-2007). We calculated this trend the same way we calculated the trends for the CMS-HCC and the ESRD dialysis factors: we first calculate average predicted costs using the most recent model (in the case of the Rx-HCC model, we have only one model) for the most recent five years for which we have complete diagnosis data. We then use these data points to estimate the annual average trend in predicted costs. We applied this annual trend for the years between 2007 to 2009 and added it to the actual trend identified by the 2007 average Part D risk score. This downward adjustment, which helps ensure that the average risk score across all Part D plans equals 1.0, will not affect total plan revenue.

For information on what prescription drug data was used for initial calibration of the Part D Rx-HCC model, see the 2006 Advance Notice, Attachment III (pages 43-48), released on February 18, 2005 on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage.

Section D. Budget Neutrality

The final estimate of the National Per Capita MA Growth Percentage is not the only factor that determines the final capitation rates for a year. The DRA specifies the components that CMS must include in the estimate of budget neutral (BN) risk adjustment factor, and codifies the phase-out of the BN factor. As in prior years, the BN factor was estimated as the difference

between aggregate payments to plans using 100 percent demographic payments and aggregate payments to plans using 100 percent risk adjustment payments, expressed as a percent of risk adjusted payments. For purposes of the calculation, CMS assumes that risk payments to plans will be at the local benchmarks, adjusted for each plan's risk score. CMS calculates a single BN factor for all MA plan enrollees.

The BN factor estimate for 2009 is 1.009. This factor was calculated based on a full BN factor of 1.038, multiplied by the BN phase-out percentage of 25 percent. As 2009 is the third year of the phase-out required by the DRA of 2005, 25 percent of the full BN factor is applied to the rates, as the same percentage for all counties.

Comment. One commenter requested that CMS release the BN factor before the Rate Announcement is released because of the shortened time frame in 2008 between release of the Announcement and the bid due date.

Response: Since CMS cannot calculate the BN factor until the final capitation rates are determined, and the final capitation rates are not determined until the National Per Capita MA Growth Percentage is determined (using the 2008 Trustees Report baseline), it is not possible for CMS to release the BN factor prior to the April 7 release of the Rate Announcement and final capitation rates.

Section E. Adjustment for MA Coding Intensity

In the 2009 Advance Notice, CMS summarized findings from our analysis of risk scores in FFS and Medicare Advantage over the 2004-2006 time period and proposed to apply a coding difference adjustment to contracts whose disease scores for stayers exceeded FFS by twice the industry average. We proposed to apply an adjustment calculated based on those contracts that fell above our threshold.

In response to the Advance Notice, CMS received a significant number of comments on the proposed adjustment for MA coding differences, most of which disagreed with our view that we had identified differences in coding patterns between MA and FFS Medicare. Based on our analysis of the comments received, and our further consideration of the question of whether differences in risk scores can be attributed to differences in coding patterns, we have again decided not to make a coding intensity adjustment for 2009.

We hope to be able to reach a more definitive conclusion as to whether differences in risk scores are attributable to differences in coding patterns prior to the Rate Announcement for 2010. In the Advance Notice, we identified differences between the risk scores of MA and FFS Medicare enrollees. However, we did not have available comprehensive information from medical records to support our hypothesis that risk score differences were driven by coding pattern differences, rather than by the health status of MA enrollees. For 2010, we intend to use the results of the first year of plan-level annual MA plan audits (see section F below) to further inform our study of coding pattern differences. .Moreover, CMS will collect additional utilization data from MA organizations to increase the accuracy of our risk-adjusted payments.

Below, we summarize and respond to the comments received on the proposed coding intensity adjustment.

(1) Legal Justification for the MA Coding Intensity Adjustment

Comment. Twenty-nine of the 30 commenters on the Advance Notice expressed views on our coding intensity proposal, and all but one of these 29 commenters opposed the adjustment as proposed. The commenter who supported the adjustment was encouraged by CMS' efforts to implement the Deficit Reduction Act (DRA) provision, but argued that CMS had too narrowly defined the subset of plans targeted to have their risk scores adjusted, and felt that CMS' effort to correct upcoding was minimal and unacceptable. Twenty eight commenters opposed the adjustment. Many contended that CMS has not demonstrated that conclusive evidence of coding differences exists, and contended that CMS had not met the requirement in the Deficit Reduction Act (DRA) that the Secretary must identify differences in coding patterns in order to adjust capitation payments to "reflect […] differences in coding patterns between Medicare Advantage plans and providers under part A and B…" Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. As noted above, CMS has determined that for CY 2009, we will not make an adjustment to risk scores when calculating 2009 plan payments. We believe that the results of the Audits discussed below in Section F will result in an ability to determine more conclusively whether the differences in risk scores we have identified are attributable to differences in coding patterns.

Comment. Authority under the DRA. Many commenters cited the Deficit Reduction Act (DRA) requirement directing CMS to adjust capitation payments to "reflect [ ] differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences" and contended that CMS has not demonstrated that evidence of such differences exists. Further, numerous commenters also cited the Conference Report for the DRA, which states that "The conferees intend that any adjustments made for the differences in coding patterns be made for differences resulting from inaccurate coding." These commenters interpret the conferees' use of the term "inaccurate" to refer to "improper" or fraudulent coding, and noted that, in the 2009 Advance Notice, CMS stated that "We do not assume that the coding pattern differences that we found in our study are the result of improper coding." The commenters thus argued that CMS does not have the authority to make adjustments based on the coding pattern differences that CMS found. Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. CMS believes that the statutory language in the DRA provision at issue provides for a payment adjustment if CMS establishes that there are "differences in coding patterns between Medicare Advantage plans and providers under part A and B." The Conference Report language necessarily must be read in light of the statutory language that Congress actually enacted.

Given the fact that the MA payment methodology is based on fee-for-service payments, and that the risk adjustment methodology is designed to compare the risk scores of MA plan enrollees to other plan enrollees and beneficiaries not enrolled in MA plans, for this comparison to be valid, MA plans must code the way Medicare Part A and B does. This would result in the MA plans' coding "accurately" reflecting the fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared. In this sense, "differences" in coding patterns, regardless of the source, would make the MA plan coding "inaccurate" for purposes of implementing risk adjustment.

This reading of the word "inaccurate" is supported by floor statements made by Senator Grassley, Congressman Barton, and Congressman Thomas. Senator Grassley made the following floor statement; the other two committee chairs made very similar statements:

> Section 5301 and the joint statement which accompanied the conference report in the Senate requiring adjustments for differences in coding patterns is intended to include adjustments for coding that is inaccurate or incomplete for the purpose of establishing risk scores that are consistent across both fee-for-service and Medicare Advantage settings, even if such coding is accurate or complete for other purposes. This will ensure that the goal of risk adjustment—to pay plans accurately—is met.

Comment. Several commenters contended that the DRA provision requiring a coding intensity adjustment did not provide for an adjustment that would be applied to a subset of plans, as opposed to the MA program generally.

Response. The DRA requires that, in "applying the adjustment under [section 1853(a)(1)(C)(i)] for health status to payment amounts, the Secretary shall ensure that such adjustment reflects. . .differences in coding patterns between the Medicare Advantage plans and providers under Part A and B to the extent that the Secretary has identified such differences." Section 1853(a)(1)(C)(ii)(I). The adjustments to capitation rates made under section 1853(a)(1)(C)(i) generally are specific to a particular MA organization. In the case of adjustments based on an enrollee's risk score, they are specific to the plan's individual enrollees. In the case of adjustments made to reflect working aged enrollees, they are made at the plan level based on that plan's enrollees.

We believe, therefore, that if we had made a final determination that an adjustment for 2009 was justified, we would have had the authority to make adjustments where we found the greatest differences in coding patterns (and where such adjustments arguably would be more necessary in order for risk scores to have the same meaning for MA enrollees and original Medicare enrollees), while not doing so where there are no such differences, or where the difference is of a smaller magnitude.

(2) Purpose of coding differences adjustment and informing of public of final methodology

Comment. One commenter contended that the Advance Notice did not make clear precisely the purpose of the proposed coding intensity adjustment, other than citing the Deficit Reduction Act (DRA). Other commenters felt that CMS had not adequately demonstrated the need for such an adjustment for coding pattern differences, and had not identified with any certainty the reasons

for the difference. Commenters suggested that there were other explanations of coding pattern differences, such as regional coding pattern differences, other than those identified by CMS.

Response. The DRA requires that CMS adjust payments to reflect "differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences." While we have reconsidered our view that the differences that we found were conclusively the result of coding pattern differences, if we had reached such a conclusion, an adjustment would have been appropriate without regard to the findings cited by commenters.

(3) Impact of plans, markets, beneficiaries

Comment. While some commenters felt that CMS too narrowly limited the number of contracts to which the adjustment would be applied, and a few others agreed with the CMS proposal to apply the adjustment to plans whose risk score change relative to FFS Medicare is significantly above the average change relative to FFS Medicare, many commenters expressed concerns that applying an adjustment to a subset of contracts was inequitable and had anti-competitive implications.

Several commenters felt that the adjustment penalized MA organizations that have been in the program longer and are now operating more efficiently. A number of commenters posited that the coding adjustment could discourage providers from contracting with plans that received the coding intensity adjustment, since MA organizations, especially those that pay providers a percent of revenue, may have to lower provider payments, which might lead to difficulty in maintaining provider networks and accessibility of care, instability in beneficiary access to care, and consumer dissatisfaction if their physicians leave the plan. Commenters also expressed concern that a coding intensity adjustment would lead to increased premiums and cost sharing and decreased benefits, and possibly cause disruption for beneficiaries who may then feel that they have to disenroll from their plan, and who may then have to switch providers. One commenter suggested that plans will lack incentive to enroll sicker, higher-risk patients. Several commenters expressed concern about the ability of plans to continue to provide appropriate care.

Response. We appreciate commenters' concerns regarding their perceptions of inequity in applying a coding differences adjustment to a subset of contracts and the market implications of such a targeted approach. Because we have decided not to make an adjustment for 2009, the above issues are moot for the 2009 bidding process.

(4) Methodological Questions and Concerns

Comment. Commenters disagreed with CMS's proposal to use the average stayer percentage to adjust the adjustment factor, in order to apply it to all enrollees, noting changes in enrollment over the time period of the study, and variations in stayer percentages among contracts as a result of different enrollee populations. Other commenters felt that an adjustment would disadvantage MA organizations with sicker enrollees. Several commenters suggested that an adjustment for coding pattern differences would discourage initiatives to improve coding, or to maintain thorough coding, since increased coding might risk a revenue reduction in future years. Several

commenters disagreed that CMS had taken into full account the degree of "catch up" and felt that a number of MA organizations would face the possibility of being penalized for these efforts.

Response. We appreciate commenters' concerns about the methodology of our approach to calculating and applying an MA coding differences adjustment. Because we are not making an adjustment for 2009, these comments are moot for this year.

Comment. One commenter suggested that CMS identify strategies for improving coding accuracy in FFS to reduce the variance in coding patterns directly related to differences in financial incentives between MA and FFS – strategies such as risk-adjusting FFS payments.

Response. CMS does make adjustments to FFS payments for diagnosis coding that is not in synchronization with a provider's case mix. We have applied an adjustment to long term hospitals that is projected to total $430 million over five years (FY 2009-FY 2013) and to home health providers that is projected to total $6.53 billion from 2008-2012.

Section F. CMS Audits

In CY 2007, CMS' payments to MA plans were 100 percent risk-adjusted for the first time because the transition from demographic-only to risk-adjusted payments was completed. Given this milestone, CMS has determined that our Risk Adjustment Data Validation, starting with CY 2007 payments, will be conducted using a sampling frame that generates statistically valid plan-level payment error estimates for those plans selected for review.

CMS will audit a subset of MA plans each year. The audit will include randomly-selected plans and targeted plans. Targeted plans will be selected based on how their risk score growth compared to FFS.

Findings from our validation studies from CY 2007 onward may inform CMS why plan average risk scores did or did not grow rapidly. This analysis will allow us to further refine our MA coding intensity adjustment. In addition, because we will have statistically-valid plan-level error estimates, we will make plan-level payment adjustments rather than adjustments to payments for specific beneficiaries whose risk scores were not supported by the medical record reviews, as we have done previously.

Section G. Adjustment to FFS Capitation Rates for VA-DOD Costs

In the Advance Notice, CMS proposed to adjust to the extent appropriate the 2009 FFS rates to reflect CMS' "estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs." Specifically, the Office of the Actuary (OACT) proposed to compare the risk-adjusted Medicare reimbursements of dual-eligible individuals — those entitled to benefits under this title and entitled to benefits from the Department of Defense (e.g., DoD TRICARE for Life and DoD US Family Health Plan) or the Department of Veterans Affairs (VA) — with individuals entitled only under this title. In cases where groupings of dual-eligible individuals

(who would possibly have services provided in VA or DoD facilities not reimbursed by Medicare) have risk-adjusted Medicare reimbursements significantly different from other Medicare-eligible individuals, we propose to adjust the MA FFS rates by excluding these individuals from the calculation.

For 2009, CMS will not make the proposed adjustment to the FFS rates. While analysis is underway on VA data, CMS has not yet received the necessary data from DoD. For this reason, CMS is unable at this time to determine the extent to which an adjustment other than zero is appropriate. CMS will continue to work on acquiring the data to support the necessary analysis.

Comment. One commenter commended CMS for moving forward with this analysis and requested an opportunity to obtain a detailed understanding of the methodology that is developed and its anticipated impact as CMS proceeds with this effort.

Response. Over the coming year, CMS is open to discussions with interested parties about the proposed methodology.

Comment. One commenter expressed appreciation that CMS is proceeding to incorporate this adjustment into the FFS rates, but expressed concern that some county capitation rates would be reduced as a result. The commenter recommended that CMS phase-in any VA-DoD-related adjustments that would reduce MA county rates to limit the negative impact on beneficiaries.

Response. As noted above, CMS is unable to determine whether an adjustment other than zero is appropriate for CY 2009. We will take the commenter's concern into account as we continue our analysis.

Section H. Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment

Comment. One commenter supported CMS's adoption of a standardized list of diagnosis codes for risk adjustment and asked if CMS would provide a crosswalk to plans between the old and new codes. The commenter also asked if CMS had done any analysis on the impact of establishing this change (e.g., estimates of increases in rejection rates and/or associated financial impact).

Response. ICD-9 codes are updated on an annual basis. You can find additional information on this process at: www.cdc.gov/nchs/icd9.htm. CMS has been monitoring rejection rates for invalid ICD-9 codes since January 2008 when edits against the standardized code set were implemented in the Risk Adjustment Processing System. CMS has seen no evidence of an increase in error rates for invalid ICD-9 codes, strongly suggesting that MA organizations were themselves operating under this standard before CMS implemented the edits. A complete listing of the risk adjustment diagnosis codes acceptable for risk adjustment prior to January 2008 and after implementation of the change in editing rules is available on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage .

Section I. Part D – Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)

In the Advance Notice, we stated that we intended to issue a final rule this Spring concerning the reporting of drug costs for Part D sponsors that contract with PBMs. We are still preparing this final rule and therefore are unable to issue the final rule this Spring as expected. As a result, Part D sponsors will not have sufficient time after the release of the final rule to prepare their 2009 bids in accordance with the policies that will be established in this rule. Therefore, for plan year 2009, as in 2006, 2007, and 2008, Part D sponsors that use a PBM may apply either the pass through or lock-in pricing approach when calculating cost-sharing and reporting drug costs. Part D sponsors must choose only one approach and cannot switch between them for purposes of calculating cost-sharing and reporting drug costs. Thus, the chosen pricing approach must be used consistently as a basis for: (i) calculating beneficiary cost-sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the Prescription Drug Event (PDE) records; and (v) developing bids submitted to CMS.

To ensure transparency in bid development, all plans will be required to submit an actuarial attestation, through HPMS and in hardcopy, which identifies the pricing approach (lock-in or pass through) that was used in the development of each 2009 bid. Additional information regarding this attestation will be issued in future guidance.

Section J. Part D - Calculation of the Low-Income Benchmark Premium Amount.

In Attachment III, Section B2 of the Advance Notice, CMS proposed to extend to 2009 the regional benchmark weighting component of the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries." We also noted in this same section that the de minimis component of the demonstration would be replaced by the final version of the proposed rule titled "Option for Prescription Drug Plans to Lower Their Premiums for Low-Income Subsidy Beneficiaries" which was published on January 8, 2008. The objective of both extending the demonstration an additional year and codifying a variation of the de minimis policy in regulation was to reduce the number of LIS beneficiaries who are reassigned to new Part D sponsors because their current plan's premium exceeds the regional LIS benchmark.

A final version of the rule was published on April 3, 2008. The final rule CMS-4133-F is titled "Modification to the Weighting Methodology Used to Calculate the Low-income Benchmark Amount." The final rule changes how the regional benchmarks are calculated and eliminates the need to extend the LIS transition demonstration. Therefore, CMS will not extend the LIS transition demonstration to 2009.

Section K. Part D - Coordination of Benefits (COB) User Fee

Comment: One commenter asked CMS to provide more information on why the COB user fee increased over 85%.

Response: The increase in the COB user fee is due to several new CMS initiatives to improve the coordination of benefits. For example, CMS is replacing the current manual TrOOP balance

transfer process with a streamlined automated transfer process. The increase in the COB user fee reflects, in part, the costs associated with developing and implementing this new automated process. CMS is also working with States to permit more frequent reporting of information regarding low-income status (full dual and LIS files for Medicare Part D). This initiative will enhance the accuracy of LIS data at point-of-sale, thus reducing Part D sponsors' reliance on Best Available Evidence. Recent legislation has mandated that all third party insurers that are secondary to Medicare provide CMS with information regarding other health insurance coverage. The COB user fee also has been increased to reflect the costs associated with receiving and subsequently providing this additional information to Part D sponsors and the TrOOP Facilitator.

Attachment IV 2009 Risk Adjustment Factors, Part D Benefit Parameters, and Other Information

The tables in this enclosure are identical to those published in the February 22, 2008 Advance Notice.

Table IV-1. 2009 Community and Institutional Factors for the CMS-HCC Model

Variable	Disease Group	Community Factors	Institutional Factors
Female			
0-34 Years		0.187	1.026
35-44 Years		0.206	0.884
45-54 Years		0.275	0.888
55-59 Years		0.333	0.943
60-64 Years		0.411	0.943
65-69 Years		0.299	0.971
70-74 Years		0.368	0.931
75-79 Years		0.457	0.835
80-84 Years		0.544	0.775
85-89 Years		0.637	0.704
90-94 Years		0.761	0.614
95 Years or Over		0.771	0.457
Male			
0-34 Years		0.120	1.030
35-44 Years		0.164	0.871
45-54 Years		0.217	0.871
55-59 Years		0.249	0.978
60-64 Years		0.389	1.015
65-69 Years		0.328	1.221
70-74 Years		0.413	1.154
75-79 Years		0.517	1.143
80-84 Years		0.597	1.087
85-89 Years		0.692	1.001
90-94 Years		0.834	0.932
95 Years or Over		0.980	0.743
Medicaid and Originally Disabled Interactions with Age and Sex			
Medicaid_Female_Aged		0.179	0.091
Medicaid_Female_Disabled		0.131	0.091
Medicaid_Male_Aged		0.166	0.091
Medicaid_Male_Disabled		0.077	0.091
Originally Disabled_Female		0.204	0.023
Originally Disabled_Male		0.168	0.023
Disease Coefficients	**Description Label**		
HCC1	HIV/AIDS	0.945	0.967
HCC2	Septicemia/Shock	0.759	0.764
HCC5	Opportunistic Infections	0.300	0.288
HCC7	Metastatic Cancer and Acute Leukemia	2.276	0.824

Variable	Disease Group	Community Factors	Institutional Factors
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.053	0.470
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.794	0.368
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.208	0.182
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation[1]	0.508	0.459
HCC16	Diabetes with Neurologic or Other Specified Manifestation[1]	0.408	0.459
HCC17	Diabetes with Acute Complications[1]	0.339	0.459
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation[1]	0.259	0.459
HCC19	Diabetes without Complication[1]	0.162	0.248
HCC21	Protein-Calorie Malnutrition	0.856	0.374
HCC25	End-Stage Liver Disease	0.978	0.654
HCC26	Cirrhosis of Liver	0.406	0.384
HCC27	Chronic Hepatitis	0.406	0.384
HCC31	Intestinal Obstruction/Perforation	0.311	0.345
HCC32	Pancreatic Disease	0.403	0.309
HCC33	Inflammatory Bowel Disease	0.241	0.205
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.535	0.497
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.346	0.215
HCC44	Severe Hematological Disorders	1.015	0.493
HCC45	Disorders of Immunity	0.912	0.427
HCC51	Drug/Alcohol Psychosis[3]	0.274	0.000
HCC52	Drug/Alcohol Dependence[3]	0.274	0.000
HCC54	Schizophrenia	0.524	0.351
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.353	0.293
HCC67	Quadriplegia, Other Extensive Paralysis	1.011	0.434
HCC68	Paraplegia	0.993	0.434
HCC69	Spinal Cord Disorders/Injuries	0.558	0.225
HCC70	Muscular Dystrophy[3]	0.395	0.000
HCC71	Polyneuropathy	0.327	0.225
HCC72	Multiple Sclerosis	0.599	0.145
HCC73	Parkinson's and Huntington's Diseases	0.592	0.092
HCC74	Seizure Disorders and Convulsions	0.267	0.177
HCC75	Coma, Brain Compression/Anoxic Damage[3]	0.415	0.000
HCC77	Respirator Dependence/Tracheostomy Status	1.867	1.559
HCC78	Respiratory Arrest	1.082	1.235
HCC79	Cardio-Respiratory Failure and Shock	0.578	0.445
HCC80	Congestive Heart Failure	0.410	0.228
HCC81	Acute Myocardial Infarction	0.359	0.424
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.284	0.424
HCC83	Angina Pectoris/Old Myocardial Infarction	0.244	0.290
HCC92	Specified Heart Arrhythmias	0.293	0.207
HCC95	Cerebral Hemorrhage	0.324	0.179
HCC96	Ischemic or Unspecified Stroke	0.265	0.179
HCC100	Hemiplegia/Hemiparesis	0.437	0.039
HCC101	Cerebral Palsy and Other Paralytic Syndromes[3]	0.180	0.000

Variable	Disease Group	Community Factors	Institutional Factors
HCC104	Vascular Disease with Complications	0.610	0.482
HCC105	Vascular Disease	0.316	0.165
HCC107	Cystic Fibrosis	0.399	0.631
HCC108	Chronic Obstructive Pulmonary Disease	0.399	0.359
HCC111	Aspiration and Specified Bacterial Pneumonias	0.703	0.573
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.249	0.181
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.252	0.497
HCC130	Dialysis Status	1.349	1.718
HCC131	Renal Failure	0.368	0.388
HCC132	Nephritis	0.125	0.253
HCC148	Decubitus Ulcer of Skin	1.153	0.485
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.449	0.241
HCC150	Extensive Third-Degree Burns[3]	1.416	0.000
HCC154	Severe Head Injury[3]	0.415	0.000
HCC155	Major Head Injury[3]	0.106	0.000
HCC157	Vertebral Fractures without Spinal Cord Injury	0.443	0.161
HCC158	Hip Fracture/Dislocation[3]	0.429	0.000
HCC161	Traumatic Amputation	0.678	0.260
HCC164	Major Complications of Medical Care and Trauma	0.296	0.309
HCC174	Major Organ Transplant Status	0.705	0.920
HCC176	Artificial Openings for Feeding or Elimination	0.662	0.841
HCC177	Amputation Status, Lower Limb / Amputation Complications	0.678	0.260
Disabled/Disease Interactions			
D_HCC5	Disabled_Opportunistic Infections	0.623	1.016
D_HCC44	Disabled_Severe Hematological Disorders	1.036	0.362
D_HCC51	Disabled_Drug/Alcohol Psychosis	0.729	0.299
D_HCC52	Disabled_Drug/Alcohol Dependence	0.310	0.299
D_HCC107	Disabled_Cystic Fibrosis[3]	1.097	-
Disease Interactions			
INT1	DM_CHF[2]	0.154	0.125
INT2	DM_CVD	0.102	0.028
INT3	CHF_COPD	0.219	0.194
INT4	COPD_CVD_CAD	0.173	0.071
INT5	RF_CHF[2,3]	0.231	-
INT6	RF_CHF_DM[2]	0.477	0.358

NOTES:

[1] Includes Type I or Type II Diabetes Mellitus.

[2] Beneficiaries with the three-way interaction RF*CHF*DM are excluded from the two-way interactions DM*CHF and RF*CHF. Thus, the three-way interaction term RF*CHF*DM is not additive to the two-way interaction terms DM*CHF and RF*CHF. Rather, it is hierarchical to, and excludes these interaction terms. A beneficiary with all three conditions is not "credited" with the two-way interactions. All other interaction terms are additive.

[3] HCC or disease interaction excluded from institutional model because estimated coefficient less than 0 or t-statistic less than 1.0.

The 2007 denominator of $7,463.14 used to calculate both the community and institutional factors is the national predicted average annual cost under the model.

DM is diabetes mellitus (HCCs 15-19).
CHF is congestive heart failure (HCC 80).
COPD is chronic obstructive pulmonary disease (HCC 108).
CVD is cerebrovascular disease (HCCs 95, 96, 100, and 101).
CAD is coronary artery disease (HCCs 81-83).
RF is renal failure (HCC 131).

SOURCE: RTI International analysis of 2004/2005 Medicare 5% sample.
SOURCE: RTI International analysis of 2004/2005 Medicare 100% institutional sample.

Attachment IV-2. Disease Hierarchies for the CMS-HCC Model

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in This Column…	…Then Drop the Associated Disease Group(s) Listed in This Column
	Disease Group Label	
5	Opportunistic Infections	112
7	Metastatic Cancer and Acute Leukemia	8, 9, 10
8	Lung, Upper Digestive Tract, and Other Severe Cancers	9, 10
9	Lymphatic, Head and Neck, Brain and Other Major Cancers	10
15	Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation	16, 17, 18, 19
16	Diabetes with Neurologic or Other Specified Manifestation	17, 18, 19
17	Diabetes with Acute Complications	18, 19
18	Diabetes with Ophthalmologic or Unspecified Manifestations	19
25	End-Stage Liver Disease	26, 27
26	Cirrhosis of Liver	27
51	Drug/Alcohol Psychosis	52
54	Schizophrenia	55
67	Quadriplegia/Other Extensive Paralysis	68, 69, 100, 101, 157
68	Paraplegia	69, 100, 101, 157
69	Spinal Cord Disorders/Injuries	157
77	Respirator Dependence/ Tracheostomy Status	78, 79
78	Respiratory Arrest	79
81	Acute Myocardial Infarction	82, 83
82	Unstable Angina and Other Acute Ischemic Heart Disease	83
95	Cerebral Hemorrhage	96
100	Hemiplegia/Hemiparesis	101
104	Vascular Disease with Complications	105, 149
107	Cystic Fibrosis	108
111	Aspiration and Specified Bacterial Pneumonias	112
130	Dialysis Status	131, 132
131	Renal Failure	132
148	Decubitus Ulcer of Skin	149
154	Severe Head Injury	75, 155
161	Traumatic Amputation	177

How Payments are Made with a Disease Hierarchy -- EXAMPLE: If a beneficiary triggers HCCs 148 (Decubitus Ulcer of the Skin) and 149 (Chronic Ulcer of Skin, Except Decubitus), then HCC 149 will be dropped. In other words, payment will always be associated with the HCC in column 1 if a HCC in column 3 also occurs during the same collection period. Therefore, the MA organization's payment will be based on HCC 148 rather than HCC 149.

Attachment IV-3. 2009 CMS-HCC Model for New Enrollees

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.496	0.807	0.000	0.000
35-44 Years	0.652	0.963	0.000	0.000
45-54 Years	0.841	1.152	0.000	0.000
55-59 Years	0.969	1.280	0.000	0.000
60-64 Years	1.094	1.404	0.000	0.000
65 Years	0.497	0.958	1.096	1.557
66 Years	0.554	0.987	1.153	1.587
67 Years	0.595	1.028	1.194	1.628
68 Years	0.619	1.052	1.218	1.651
69 Years	0.652	1.085	1.251	1.684
70-74 Years	0.759	1.208	1.320	1.769
75-79 Years	0.955	1.357	1.430	1.832
80-84 Years	1.118	1.520	1.593	1.995
85-89 Years	1.255	1.657	1.730	2.132
90-94 Years	1.358	1.760	1.834	2.236
95 Years or Over	1.232	1.634	1.707	2.109
Male				
0-34 Years	0.344	0.675	0.000	0.000
35-44 Years	0.583	0.914	0.000	0.000
45-54 Years	0.729	1.060	0.000	0.000
55-59 Years	0.827	1.158	0.000	0.000
60-64 Years	1.033	1.365	0.000	0.000
65 Years	0.550	1.022	1.116	1.587
66 Years	0.586	1.058	1.117	1.589
67 Years	0.664	1.136	1.195	1.667
68 Years	0.664	1.136	1.195	1.667
69 Years	0.723	1.195	1.254	1.726
70-74 Years	0.855	1.322	1.392	1.859
75-79 Years	1.113	1.484	1.521	1.893
80-84 Years	1.299	1.670	1.707	2.078
85-89 Years	1.468	1.839	1.876	2.247
90-94 Years	1.630	2.001	2.038	2.409
95 Years or Over	1.638	2.009	2.046	2.417

NOTES:
The 2007 denominator of $7,463.14 used to calculate the new enrollee factors is the national predicted average annual cost under the model.

Three sets of interaction coefficients were constrained to be equal (Male, Age 67 & Male, Age 68; Medicaid, Male, Age 65 & Medicaid, Male, Ages 66 to 69; Originally Disabled, Female, Age 65 & Originally Disabled, Female, Ages 66 to 69). These constraints are necessary so that predicted expenditures, and risk scores for all demographic groups, vary in a reasonable way, as shown in the table of mutually exclusive demographic groups.

SOURCE: RTI International analysis of 2004/2005 Medicare 5% sample.

Table IV-4. Final Recalibrated Frailty Factors for CY 2009

ADL	2008 Factors (Non-Medicaid)	2009 Recalibrated Factors (Non-Medicaid)	2008 Factors (Medicaid)	2009 Recalibrated Factors (Medicaid)
0	-0.089	-0.093	-0.183	-0.180
1-2	+0.110	+0.112	+0.024	+0.035
3-4	+0.200	+0.201	+0.132	+0.155
5-6	+0.377	+0.381	+0.188	+0.200

Table IV-5. Data sources for the assignment of Medicaid status

	Payment year 2007	**Payment year 2008**	**Payment year 2009**
New enrollees	1. Third Party Buy-In file 2. Plan-reported Medicaid • Batch "01" transactions • Retroactive "01s" through IntegriGuard	1. MMA State files 2. Plan-reported • Retroactive "01s" through IntegriGuard	1. MMA State files 2. Plan-reported • Retroactive "01s" through IntegriGuard
Full risk enrollees		1. MMA State files 2. Third Party Buy-In file 3. Plan-reported Medicaid • Batch "01" transactions • Retroactive "01s" through IntegriGuard	

Notes: Full risk enrollees. CMS considers full risk Medicare beneficiaries as dually-eligible if they were eligible for title XIX during any month in the year prior to the payment year. Full risk Medicare beneficiaries have 12 months of Part B in the year prior to the payment year.
New enrollees. CMS assigns Medicaid status for new enrollees on a concurrent basis, i.e., if a newly-enrolled Medicare beneficiary is eligible for title XIX during any month during the payment year, they are considered Medicaid for that year.

Table IV-6. Acceptable diagnoses codes

Year of Payment	**Date of Service**	**Source of codes**
2007	1/06 – 12/06	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2008	1/07 – 12/07	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2008, 2009
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2009, 2010
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2010, 2011

Table IV-7. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Annual Percentage Increases	Annual percentage trend for 2008	Prior year revisions	Annual percentage increase for 2008
Applied to all parameters but (1)	5.97%	1.48%	7.54%
CPI (all items, U.S. city average): Applied to (1)	2.60%	0.57%	3.18%

Part D Benefit Parameters	2008	2009
Standard Benefit Design Parameters		
Deductible	$275	$295
Initial Coverage Limit	$2,510	$2,700
Out-of-Pocket Threshold	$4,050	$4,350
Total Covered Part D Drug Spend at OOP Threshold (2)	$5,726.25	$6,153.75
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Part D Full Benefit Dual Eligible Parameters		
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	$1.05	$1.10
Other (3)	$3.10	$3.20
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Above Out-of Pocket Threshold	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters		
Resources ≤ $6,290 (individuals) or ≤ $9,440 (couples) (4)		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Resources bet $6,290-$10,490 (ind) or $9,440-$20,970 (couples) (4)		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Retiree Drug Subsidy Amounts		
Cost Threshold	$275	$295
Cost Limit	$5,600	$6,000

(1) CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% FPL.
(2) Amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.
(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2008 values of $55.91, $1.04, and $3.13 respectively.
(4) The actual amount of resources allowable will be updated for contract year 2009.

Office of the Actuary, Centers for Medicare and Medicaid Services, February 22, 2008